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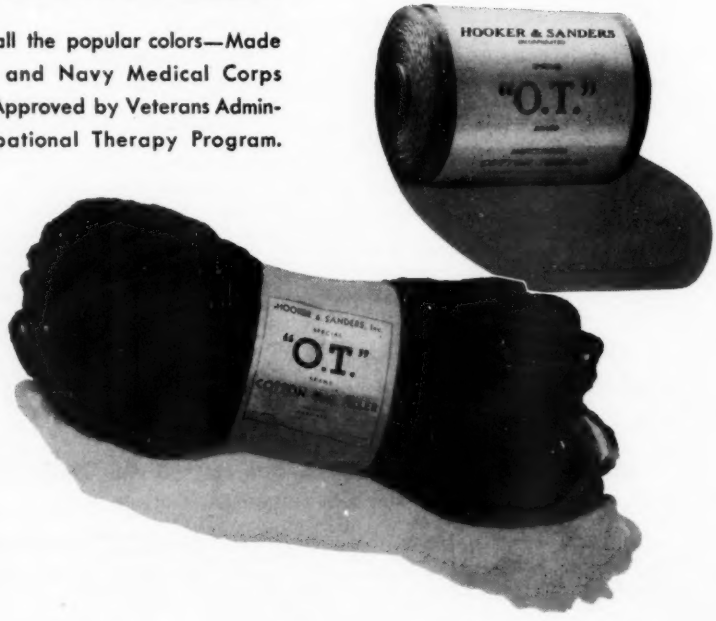

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The Use of Therapeutic Activities in Psychiatry

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Washington, D. C.

The function and aims of recreational therapy have, from time to time been defined in the literature, but the process through which these aims are achieved is still inadequately understood.

It is necessary to clarify this question, to study the modus operandi of therapeutic recreation and occupation if these treatments are to be applied in such ways as will exploit their maximum benefits. Clarification of this question is a large task and this discussion aims to report a few experiences in the use of therapeutic activities in the hope that some directions in which further inquiry can be made will suggest themselves.

No sharp distinction is drawn here between occupational therapy and recreational therapy. Both activities are therapeutic and the principles discussed apply equally to both. In practice, occupational and recreational therapy inevitably overlap; they embrace a variety of activities which range from pure play to complicated work while including some, like gardening, which are on the borderline of work and play. In some centers, separate departments of occupational therapy and recreational therapy exist; in others they are jointly administered. The training of the occupational therapist is now standardized; the training and background of the recreational therapist varies considerably. Sometimes the recreational therapist has received his training in the schools of occupational therapy; sometimes he is a college graduate with a major in physical education. Occasionally, the recreational therapist has had no special training but is a former hospital attendant who because of his athletic interests has been drafted into recreational work. These non-graduate therapists often manifest considerable sensibility in their relations with mentally ill people and are very effective in their work. Without sacrificing the skills of these valuable workers, it is desirable that plans be made which will permit all workers at present engaged in the field to achieve standard professional qualifications and which will establish minimal qualifications for recreational therapists in the future. Such measures would facilitate coordination of treatment and research efforts.

The value of therapeutic activities has already been demonstrated in many ways. Since their use has become widespread, the psychiatric hospital has taken on a new aspect. There are far fewer disturbed patients, and the hospital functions in a more orderly, smoother manner. To say the least, administrative problems are simplified; but there is good evidence also that the duration and severity of illness are lessened. At one hospital the installation of a recreation yard adjacent to the disturbed ward was followed by a marked reduction in the amount of

sedatives and sedative hydrotherapy that was prescribed. The patients were more content. Nurses and attendants freed from routine custodial work join with the patients in games and group activities.

Occupational and recreational therapy exert constructive socializing influences. Friendships are formed in the shop and on the ball field; barriers broken down. The patient may discover that his problems are not unique and that other people are less terrifying than is the fantasy of them that he has formed and expanded in his solitude. This development, the approximation of other people to reality, may lessen the patient's need for his symptoms, his defenses against real relationships with others. Various writers have reported that their patients have shown a diminution of delusional, hallucinatory or phobic manifestations when engaged in recreational work. This is doubtless due to the fact that in the course of the work which brings him closer to other people the patient's picture of them becomes more realistic.

Again, the feeling of self regard may be considerable enhanced by the planning and completion of some simple piece of work. To the schizophrenic patient in particular, oppressed with thoughts of past failures, the simplest achievement can prove vastly important and further his confidence in the therapeutic process as a whole. The experience of success makes some inroad in the destructive, self-depreciatory processes that characterize his illness and permits the re-emergence of reparative trends in the personality.

In the treatment of medical and surgical disorders other valuable observations as to the usefulness of therapeutic activities have been made. In Toronto, a curative workshop was opened under the auspices of the workmen's compensation board. It was understood that the shop would operate for one year and its budget would not be reappropriated if it did not pay for itself. So great was the saving in compensation payments after one year that the budget was doubled by the provincial government. The work was concerned with industrial accident cases, but the great reduction in the period of convalescence that was effected was certainly due to the fact that the therapists recognized emotional factors that were prolonging illness and directed the treatment toward them. Similar experiments have been duplicated successfully in other centers.

MODE OF OPERATING

Admitting, then, that recreational therapy is of value, we are challenged with the necessity of studying more closely its *modus operandi* both through the interpersonal influences involved and through the influence of the specific activities prescribed.

As a background to the whole problem of treatment it must be recognized that the environment of a good or even average psychiatric hospital is in itself therapeutic. No matter how unskilled in psychiatric techniques the attendants or other workers may be, their personal attitudes towards the patient are neutral in comparison with those of the patient's family in relationship with whom the patient has reached an impasse in the struggle with ambivalent feelings. In the new, relatively neutral environment it is possible for him to reach out afresh for less complicated personal relationships. These sometimes appear first between patient and doctor. In other instances, especially in hospitals where there are few doctors, the patient establishes his first relationship with the nurse, attendant, or recreational therapist. These early relationships which have genuine therapeutic potentialities usually develop without planning or conscious guidance. A therapist is often unaware of the great importance to the patient but manifests, nevertheless, an attitude that is so much more realistic than that previously encountered by the patient, that therapeutic benefit results. In consequence, the patient is helped to the establishment of useful therapeutic relations in the hospital environment. In many instances, it is because of this fact that in hospitals where no opportunities for personal treatment exist, a significant proportion of patients recover. Since so much benefit, then, occurs fortuitously, is it not reasonable to suppose that much more would be accomplished when more therapists are alert to the importance of their therapeutic relations with their patients? Recent experience indeed, in the use of group psychotherapy in large institutions, strongly supports this view. It is therefore necessary that as many therapists, doctors, nurses, occupational therapists, receive such training as will render them more aware of the dynamics of personal relations. It is only in so far as a recreational therapist has such understanding that she differs from the "lady companions" who worked faithfully but without the benefits of modern psychiatry in our hospitals a hun-

dred years ago. By what means an expansion of the awareness of the therapist in the field of personal relations can best be achieved is a problem for thorough and immediate inquiry. It might possibly include some form of group psychotherapy or psycho-drama in the post graduate training of therapists. It might be achieved by individual supervisory conferences with a psychiatrist. These methods have already been applied to the training of social workers.

In returning to the study of the nature of the treatment process, it might be useful to retrace the experience of the patient from the time of his admission to the hospital. The possibility of treatment is first brought to the attention of the patient in the admission office. In this situation the patient's attitude towards the doctor who meets him are inevitably complicated by his own past experiences and he is filled with distrust. If however, he is met in a simple, non-hostile way, he will take note of this new attitude. Treatment has then begun. When the patient encounters others in the hospital who display this attitude of simple frankness, he is more deeply impressed. In the admitting office, the doctor has a good opportunity to tell the patient in the clearest terms something of the treatment program including the therapeutic activities. To the patient, perplexed by the admission routines, the reference to what is going to be done for him, is often highly reassuring. Later, when meeting the recreational therapist, the patient may recall that the doctor spoke of the activity program and indicated his belief in it. As a result, the patient is more likely to participate.

Shortly after the patient's admission, the doctor sends a preliminary written prescription to the occupational therapist. This informs the therapist of the patient's clinical syndrome, offers suggestions as to the approach to the patient and advises on problems of management and supervision. The real treatment of the patient however, depends less upon prescriptions than upon the regular conferences which doctor and therapist hold thereafter. It is obviously necessary that therapist and physician compare notes frequently both to coordinate their working direction and to discuss their personal attitudes towards the patient, airing in the process such difficulties as inevitably occur. Many serious problems can be resolved when such frank conferences are held and when indicated, they should include other personnel.

CASE No. 1

A patient convalescing from a schizophrenic illness annoyed others by his constant teasing and interference with their activities. As a result, other patients avoided him and because of the persistence of his difficult behavior, personnel whose duties did not require that they work with him, began to stay out of his way. The patient's teasing activities became more marked as he became aware of his unpopularity. A conference was held of ward nurses, occupational therapists, in which everyone aired their private views of the patient, sometimes with considerable vehemence. As a result of this frank discussion and through the excellent suggestions of those who appreciated the patient's behavior as an attempt to test the environment, a more discerning attitude developed among the personnel. A new feeling developed towards the patient which led several of the personnel to show him, of their own volition, many evidences of friendly attention. In a short time the patient's difficult behavior ceased and his subsequent progress has been uninterrupted. The conference of the various therapists which was, indeed, a sort of group psychotherapeutic session, resulted in a turning point towards recovery for the patient.

Similar problems which can be ironed out in personal or group conferences frequently occur.

The patient's unrecognized antagonisms may express themselves in efforts to provoke disharmony between doctor and therapist. These efforts, often managed very plausibly, are apt to succeed unless thoroughly understood and discussed. If actual disharmony does result, the patient is always the loser. If the motivations involved are recognized, however, the psychotherapist can utilize them to the patient's advantage in therapeutic interviews.

In the pursuit of recreational activity, constant opportunities arise for enlightening the patient as to vital problems in his personal relations. Those situations, for instance, in which matters of pre-eminence and competition come to the fore, can be noted by the therapist and discussed with the physician so that they can be turned to psychotherapeutic account. At the same time the physician must keep in mind that a reference that the patient makes to his activity program is not to be dismissed as an irrelevant comment but may represent an at-

tempt to elucidate some problem which has been brought to the surface by the experience of the recreational work. The therapist sometimes reports to the physician manifestations of behavior and attitudes which the doctor had not observed in treatment sessions. Similarly, some growth in insight might first reflect itself in some change in the patient's attitude toward the recreational group.

A comment made by the psychotherapist may not become meaningful until the patient encounters experience in group work which highlights the doctor's observation.

One patient said that while painting in the hospital studio he would often recall comments that the doctor had made during treatment sessions and would see some significance of these which he had not been able to recognize during the treatment hour. He expressed the belief that in the course of this activity therapy tensions were released which had barred his acceptance of the doctor's interpretations at the time they were given. As a result, he could see a broader meaning in the treatment plan

In one hospital an effort has been made to study the interworkings of psychotherapy with other therapeutic activities by the use of a questionnaire circulated to each department. Such questions as: "During his work in your department has the patient manifested any evidences of antagonism?" have been asked. A variety of other questions correlating evidences of the patient's progress can be prepared.

A practically mute schizophrenic girl went to the occupational shop regularly for several weeks. It was noted that she worked assiduously provided the therapist stood near. The patient's behavior was reported to her psychotherapist who gradually elicited from the patient her account of the experience. The patient said that she had felt that occupational therapy was compulsory and that the quality of her work was very severely judged. She believed that the therapist expected her to work at great speed and utilize every minute. If the therapist paid any attention to another patient, she was convinced it was because the therapist disliked her. These problems were studied in relation to their origin in the patient's strict family background. As a result the patient's attitude towards occupational therapy became much more realistic. Later she attended the shop when she felt an interest in going and was no longer concerned as to whether or not her work was perfect. The therapist reported that her need for reassurance was greatly lessened.

This patient had carried over into the hospital environment personal attitudes drawn from her own past. From the study of these attitudes, much was learned of the influence of significant people in her formative years. The rebellious patient who declines to take part in group work and the passively cooperative person who obeys every rule and makes no objections of his own may both be living out unresolved attitudes towards their parents.

Incidentally, it is important to be alert to the problem which the passive, docile patients present. Very often, because of their apparent willingness, such patients are assigned to simple, routine tasks as counting linen which contribute to the housekeeping but only perpetuate their neuroses.

Hitherto, this discussion has centered around the influence of personal relations in recreational therapy. A study of these relations must be accompanied, however, by an evaluation of the activities themselves and the part that they play in promoting the socializing aim. By this means, therapeutic activities can be found which are most closely suited to the patient's needs.

At the Menninger Clinic an attempt has been made to apply the psychoanalytic theory to recreational therapy in an effort to meet directly the causative unconscious problems.

For instance, a patient who shows evidence of suppressed antagonism is assigned some aggressive activity such as cutting down trees or wrecking a building. Depressed, self-accusatory patients with a strong drive to humiliate themselves have been given menial tasks in the kitchen.

In Baltimore and Washington, a group of therapists held seminars to discuss means of rendering their programs more flexible. They compared various recreational activities in the extent to which they tended to promote relaxation and social intercourse. Rhythmic dancing and finger painting were found by this group (as well as by others) to have a special value in providing release of tension. A seminar devoted to the group composition of music was reported. The instructor expressed her belief that all people have an ability to improvise tunes and that this ability is rarely recognized and developed. She was able to show the group how, with an experienced leader at the piano, members of the group could contribute a line

of song here and a bar of music there and the whole could be then harmonized by the leader and sung in unison. The group, most of whom were untrained in music, responded enthusiastically and very successfully. The immense surprise and pleasure at the discovery of a previously unrecognized ability convinced them that musical composition offered great possibilities for therapeutic use.

If a recreational pursuit provides this opportunity for experiencing a sense of discovery, its therapeutic value is greatly enhanced. A patient who has no interest in dramatics for their own sake but who has made a piece of stage furniture may derive great surprise and satisfaction when he sees his work as part of a finished performance. He may also be surprised to realize the importance of his own contribution to the group effort.

In providing the opportunity for the experience of surprise, shop-work is sometimes valuable. Many patients, because of a marked disbelief in their ability will decline shop-work, saying "They have never been good with their hands." If they are encouraged to try shop-work they sometimes enjoy it and prove quite successful in it.

CASE No. 2

A middle-aged, depressed physician complained that his life had been dull and unvaried. In the hospital, he refused suggestions for recreation saying that he had never played and knew nothing but medicine. He spent much time with another patient of his own age whose symptoms were similar to his but who, prior to his illness, had been intensely interested in outdoor sports. One day the physician-patient approached the recreational therapist saying that he believed his companion would be helped if he regained an interest in golf. The therapist suggested that the three of them play together. This was at first agreed to reluctantly; but before long the two men, with mutual encouragement, were playing golf daily and attending athletic events outside of the hospital. Gaining confidence, the physician-patient expressed an interest in handicraft and went to the metal shop. He made a very simple ashtray, was delighted with the result and thereafter pursued the work regularly. Following his recovery, he equipped a metal shop in his home and maintained his interest in outdoor recreation.

Experiences of a somewhat similar nature have been encountered with patients who have achieved great success in athletics but have relied upon the prestige derived from this source for the maintenance of their equilibrium. Prescription of some untried activity, especially shop work, has proven helpful to these patients.

CASE No. 3

A young schizophrenic man, an outstanding college athlete, ridiculed the shop activities and spent most of his time on the tennis court. The occupational therapist, recommending a change of activity, suggested that he try his hand at chip-carving. The patient was, in contrast to his confidence in outdoor games, remarkably timid at exposing his lack of skill. After painful efforts, however, he completed a carved design on a box lid. He was genuinely delighted, experimented with new tools and learned to do electrical repairs. The experience was doubly beneficial to him. He not only gained confidence in trying new things; but, while struggling through his first attempts at woodwork, he came to recognize that the other patients, whom he had formerly despised because of their lack of athletic prowess, possessed more competence than he in other fields.

In the experience of the two patients described, the choice of activities became connected with the later development of hobbies, although this was not the original intent of the therapist.

There are occasions, however, in which educational and re-educational work are indicated. This is true of adolescent patients who have been detached, sometimes for periods of years, from association with their contemporaries and have in consequence missed the constant experience of adaptation to other boys and girls which is essential to development. During their convalescence, such patients are often self-centered and dictatorial, behaving like children of six or seven years of age. Their self esteem is considerably weakened, and they are ill-prepared to face the difficulties of adjustment to more experienced adolescents that will confront them in the high school. The recreational therapist can help them to expand their experience in sharing and living with each other and, at the appropriate time, can provide actual aid in preparing them for their high school studies. The concern that these patients manifest over loss of school work is, however, frequently in-

fluenced by family pressure for scholastic achievement, and this possibility must be carefully evaluated before any plans for study are carried out. If educational courses are decided upon, close collaboration between recreational therapist and teacher is required. At a later stage in convalescence, arrangements have sometimes been made with local school authorities for patients to take courses at high school while completing their recovery at the sanitarium.

Problems in which re-educational elements appear are encountered in private practice in the treatment of ambulatory schizophrenics or schizoid characters. As psychotherapy proceeds and previous inhibitions are relaxed, such patients may discover new interests and talents within themselves for which they seek outlets. They often begin to write or play the piano, discussing their work with the doctor or showing him their manuscripts. Occasionally, they pursue dramatic or other creative work in some local group. The recent growth of community art and recreational groups has proven valuable to many of these patients, and it is worthwhile for the practising psychiatrist to keep informed of them.

CASE No. 4

A 27-year-old man consulted the physician because of the presence of marked anxiety in relations with people. Because of strong family pressure, he had spent practically all of his spare time in boyhood working in his father's store. He said, "I never knew what play was." He had developed a docile, cooperative manner in dealing with his superiors, which, added to his habits of industry, enabled him to maintain a successful working adjustment. He always got along better with his bosses than with his equals at work, which helped to gain him steady promotion but also kept him constantly uneasy since he feared that he was regarded as the teacher's pet. While under treatment, he was invited by a fellow worker to join the office bowling team. On the first evening at the bowling alley he became acutely anxious when he felt that one of the women employees was watching his performance. He had an urge to run home, but finished the game and discussed the problem at his next therapeutic hour. "Even though the experience was painful," he told the doctor, "I had a feeling that it was something from which I could learn." Further associations to this incident revealed significant data regarding his relationships with his mother and sisters, which illuminated the causes of his anxiety. While discussing these matters, he was able to express considerable resentment at the restrictions of his childhood and at the same time to recognize how these evolved from his parents' emotional difficulties. He continued as a member of the bowling team and was genuinely delighted when two or three weeks later one of the members invited him to join a fishing party saying, "You seem to be the sort of a fellow that fits in with our crowd."

So far, discussions of the workings of the therapeutic activities have been limited to the individual, but it is important also to devote some consideration to the group therapeutic effect of occupation and recreation. The development of group psychotherapy has called attention to the highly significant therapeutic phenomena which take place between patients when working together in the understanding of their problems. Little is so far known of similar phenomena which must exist in group recreational work. It is necessary to understand these phenomena if their socializing influences are to be fully utilized. Such a study might usefully begin with research into spontaneous group activities.

It has been repeatedly observed that activities spontaneously inaugurated both with the individual and the group often produce intensely satisfying results.

The pleasure that any group of people finds in an informal "bull session," whether it be at the club, in the college dormitory or on the ward of a psychiatric hospital, can be memorable. Informal sing-songs and dances are sometimes more successful than the more formal pre-arranged events. In the psychiatric hospital, everything should be done to make them possible.

CASE No. 5

On a convalescent ward there was a large proportion of young men, several of whom rebelled continually at the hospital routine. They declined to participate in group activities and spent much of their energies in devising ways of provoking the administration and discouraging other patients. It was suggested that they try to achieve some measure of self-government. As a result, they held an election for a ward manager.

Intense excitement surrounded the election campaign, and daily caucuses of interested members of the staff and personnel were held. The ward began to operate under its own power. Several spontaneous group projects were undertaken including a minstrel show and later a revue, in which various members of the staff were lampooned. A communal feeling developed which was strong enough to overcome the disruptive influence of the rebellious psychopathic patients in the group.

In this instance, the spontaneous activity took the form of a group rebellion against authority. When this attitude was met in a conciliatory manner and the group was given an opportunity to work out a constructive plan, a group spirit developed which had therapeutic value and solved, incidentally, a difficult administrative problem. Similar results with spontaneous activity groups in a military psychiatric unit have been reported by S. H. Foulkes. His patients selected ward committees, formed clubs and assisted, as far as possible, in the formulation of hospital policy. These activities were accompanied by group psychotherapy in which the therapist encouraged full exchange of opinions and assisted in formulation of group and personal problems. There are certain types of group activity which have an especial quality of spontaneity about them. Notable among these are winter sports and other outdoor activities particularly swimming, picnicking and camping activities which tend to recall pleasurable experiences of youth. In doing so, they may also arouse feelings of optimism for the future.

It would seem advisable for recreational therapists to develop these activities as fully as possible and perhaps to expand them by arranging for occasional overnight camping or fishing trips. Such experiences should stimulate a recognition of the need for mutual dependence and thus foster companionship.

The roles of the occupational and recreational therapist in group treatment have still not been fully defined. It is clear, however, since it will be many years before the doctor shortage is overcome, that a great deal of treatment and research, if it is to be carried out at all, will have to be done by non-medical personnel. Occupational and recreational therapists can expand their usefulness by learning and applying some of the principles of group psychotherapy. For instance, current events groups can be arranged in which the therapist participates in a passive manner reporting observations of therapeutic phenomena in regular supervisory interviews with the doctor. This might result in the therapist's receiving some additional training in the principles of group psychotherapy. In some military centres, group psychotherapeutic work has been carried out by non-medical personnel trained and directed in their work by psychiatrists. It would seem possible to draw from these efforts some principles which could expand the scope and effectiveness of occupational and recreational therapy.

Many favorable things have been said in this discussion about occupational and recreational therapy, but it is not meant to imply that these are "cure-alls." As in all forms of treatment, many patients will fail to respond; others will recover without benefit of therapy. There are always some patients who, without disproportionate resentment, prefer to pursue their own inclinations and do not avail themselves of the recreational program. These instances are not to be regarded as therapeutic failures. On the contrary, a careful study of the patient's self-chosen activities may yield something which may be of value to others. Incidentally, it may be found that the therapist has some unrecognized part in what the patient is doing. In any event, these are opportunities for research in spontaneous therapeutic activity which may lead to a clearer definition of the role of the therapist and of the treatment, an evolutionary step in therapeutic psychiatry.

SUMMARY:

Therapeutic activities have been discussed from the standpoint of the interpersonal relations involved and the effect of the specific activities selected. It is recognized that the benefit that a patient receives is rarely traceable to a single form of treatment. In consequence the need for close coordination of psychotherapy with activity therapy is stressed. Some experiences with group activity have been described. There is need for research into means whereby the knowledge recently gained in the practice of group psychotherapy can be adapted to a more effective use of group therapeutic activity. This might involve some expansion of the field of the occupational therapist to include a more conscious use of psychotherapy. The possibility of training some graduate therapists in the principles of group psychotherapy should be studied. *(Continued on Page 96, Col. 1)*

Vocational Rehabilitation of State Hospital Patients
A Preliminary Report of a Study in Connecticut

TEMPLE BURLING, M.D.
Division of Rehabilitation of the National Committee for Mental Hygiene.

For about four years the State Offices of Rehabilitation have been authorized to accept the mentally handicapped as well as those with physical disabilities, but despite the very large numbers of people who are handicapped by mental and emotional illnesses, relatively few have so far received help from the government agencies. A few state bureaus have done considerable work with ambulatory psychoneurotics but the psychotics have been almost completely left out of the program. About two years after the new law had been in effect, only one-half of one percent of all referrals throughout the country came from state mental hospitals. Because of this, the National Committee for Mental Hygiene has undertaken a study of the vocational rehabilitation of the mentally handicapped and particularly of how rehabilitation services may be made available to patients discharged or paroled from mental hospitals. Studies are being made in the New York City area and in Connecticut with some supplementary studies in Michigan. This report will be confined largely to the work in Connecticut.

Our first concern was to determine the reasons for the apparent neglect of the state hospital population. The first guess which any one unacquainted with the present day result in state hospitals would probably hazard is that few people are being referred for vocational rehabilitation from these hospitals because few people recover. A pessimistic attitude toward mental illness has been so thoroughly implanted in the mind of the general public, that it is extremely difficult to convince those who don't have direct contact with our psychiatric institutions that psychotics do get well. In fact, sometimes even direct contact isn't enough. Not long ago a group of nurses spent a day as guests of one of the state hospitals, visiting wards and occupational therapy rooms and observing all the varied activities going on at the institution and in addition heard discussions by various staff members of the program and its results. Yet in the evening when there was a question period, one of the nurses asked the Superintendent, "Do any of these people ever get well?" The answer to that question is an emphatic "Yes." They do get well and in large numbers, in spite of the understaffing and inadequate facilities due to indifferent public support. The therapeutic armamentarium has increased enormously in the past few decades and even though much of it remains purely empirical, it does get results. Each of the three state hospitals in Connecticut discharges or paroles every year close to 2000 patients.

This is not always an unmixed blessing. In an article in the American Journal of Psychiatry for December 1947, Drs. Feldman, Susselman and Barrera of Albany Medical College, say: "There has been a subtle shift of responsibility for the care of the mentally ill from the state to the individual family. In many instances the family has been burdened with issues other than the immediate care of the patient and including changes in their living habits." If successful therapy necessarily meant that custodial care were shifted from the hospital which is organized and provided with trained personnel for this task, to the poorly prepared family, this would be a retrograde step. When these people return to the community, the community must share the responsibility with the family. When the community does its part, large numbers of these people can become assets rather than liabilities. For, with a little help, many of them can make a thoroughly satisfactory social and vocational adjustment.

In fact, when one gets acquainted with any considerable number of the patients who have left the hospital or are about to do so, and learns of their post-hospital history, he begins to wonder if perhaps the reason that so few have been referred for vocational rehabilitation is that there is no need for it. A very large percentage of them have a position waiting for them in the community to which they return and which they fill satisfactorily without any organized help.

Because such a large percentage of patients

who have left mental institutions were obviously making satisfactory adjustments through their own efforts, one of the first things we did was to attempt to find out how many there were who really were in need of the sort of services that the Rehabilitation Office has to offer. This study isn't complete, but we have some indications. We found, as had been expected, that a very large number of women patients were married and in almost every instance these women on leaving the institution were able and wished to resume their household duties. We found also that most people who have had a satisfactory vocational adjustment before their mental breakdown are able to pick up where they left off. Farmers returned to their farms. People who have been in independent business, nearly always find on leaving the institution that family and friends have kept it going and they are able to return to it. But, more surprisingly, people who have been employed return to their old jobs. We have found almost no instances of employers being unwilling to take employees back after recovery from a mental illness. The only instances we have found are organizations so large that employment policies are governed by fixed rules. For instance, one man neglected to obtain extended leave of absence and thus lost his Civil Service Rating and there was no provision in the law by which he could be re-instated. Nevertheless we did find that there are a good many patients who are at a loss to find employment.

There are two chief groups. The first, a small one, consists of patients who have been in the hospital so long that they have lost their vocational skills or these skills have become obsolete, due to technilogical changes. The second, and by far the largest group consists of young people whose breakdown has occurred so early that they have not established themselves vocationally and not infrequently have not even determined on any clear vocational goals.

In addition, we find very rare instances in which the previous occupation was apparently a contributing cause in the breakdown, so that a change in occupation is very desirable. For example, there is an alcoholic who was formerly employed as a bartender. Another, and a small group, is that of women who lose their husband's support by death or separation during hospitalization and who either have never been previously employed or have been too long out of the labor market to find it easy to get back into it. And there are some patients whose recovery is incomplete and who are employable but not able to go back to the same level of vocation which they occupied successfully previously. All in all our studies indicate that between five and ten percent of the patients leaving the hospital are in need of professional help in making a vocational adjustment.

So, we are still faced with the question of why haven't these five or ten percent been referred for service. The answer is to be found partly in the Office of Rehabilitation and partly in the state hospital. In the past, the rehabilitation counselors have not been eager to get these clients. They have had no more opportunity than other informed laymen to know what mental patients are like and they are apt to have rather frightening and distorted ideas about them, or at least to feel that dealing with such people requires an extremely high degree of tact and skill. They have therefore accepted them when referred but have not made any serious efforts at casefinding, as they have in regard to various categories of physical handicaps. The state hospital, on the other hand, is burdened with a serious problem of isolation from the community from which it is nearly always geographically remote. There is little opportunity for contact between the hospital staff and the other welfare agencies. The social service staff on whom falls the chief responsibility for liaison between the hospital and the community is in nearly every instance tragically understaffed, and the other professional employees are kept so busy with the care of patients in the hospital that they have no opportunity to acquaint themselves with what happens to any number of their patients after return to the community. As a result, the state hospitals have only rarely called upon the rehabilitation workers for help. One state hospital superintendent said, "I've been on the Psychiatric Advisory Board of the Division of Rehabilitation for two years, but it never occurred to me that they had anything to do with my hospital."

We have found however, that once attention is called to the vocational problem of these people there is very great interest on both sides, but we have also found that interest alone isn't enough. There is need to organize the cooperation between the two. The Rehabilitation Offices have had a great deal of experience in co-operation with other types of hospitals. For

example, there is a well organized program of co-operation with the tuberculosis sanitoria and one might suppose that the machinery that has proved successful there could be employed successfully in mental hospitals. Somewhat surprisingly this is not the case. For one thing, the needs of the tuberculous and of the psychotic differ and the tuberculous patient needs to be helped to find a job which will not undermine his health and very frequently then needs training for it. The need for vocational training apparently is far less frequent with the psychotic. I will discuss the psychotic's vocational needs in more detail presently. The most surprising difference is that the length of stay in the institution for the tuberculous is a great deal longer than of the patient who is successfully treated in the mental hospital. Also the prognosis of the tuberculous patient is very much more exact and easily determined than that of the psychotic patient. It is possible almost with the first examination to furnish the vocational counselor with sufficient data to make fairly definite vocational plans and to initiate the program for reaching that goal very shortly after the patient's admission. On the other hand, by the time the doctor can say with reasonable assurance that the psychotic is going to be able to leave the institution, he is just about ready for parole. It is only when he is pretty close to the date of leaving that he himself is able to participate in making plans with the counselor. Because of the relatively unpredictable course of mental hospital patients, while in the institution, casefinding of patients needing rehabilitation cannot be very completely routinized. It is imperative that the question of vocational plans be brought up at all parole conferences and it is desirable that at the initial conference the question be raised as to what can be planned even early about meeting the problem. But it is even more important that all professional members of the staff be on the alert at all times for indications that the moment is opportune to consider the vocational future of a patient and to refer him to a rehabilitation counselor. There is much evidence that if possible the patient should be referred while still in the institution, for if the counselor can visit the patient and begin to make plans with him before his parole, rapport is very much better than if he is urged to visit the Rehabilitation Office at the time of leaving the institution or after his return home. It should be obvious too that an active effort toward vocational adjustment while the patient is still in the hospital should have a valuable therapeutic effect. In one of the Connecticut State Hospitals at the present time there is an experiment with the Division of Rehabilitation in which one of the counselors has been assigned full time to the hospital. The hospital is furnishing him office space and clerical help and he attends Staff conferences and participates in the discussion. He is on hand for conferences with hospital staff members and patients can be referred to him promptly when they manifest a readiness to make plans for the future. And the face-to-face relationship between the counselor and the hospital staff makes possible a mutual education that could never come about through written reports.

The services offered by the Division of Rehabilitation are varied. For the physically handicapped, one of the most important of these is the procuring of medical and auxiliary treatment for the handicapped. The patient referred by the State Hospital obviously is not in need of this. Treatment will have been almost completed before the patient is referred. One of the most important services for the mentally handicapped is counseling. These patients need frequent opportunities to talk over their plans, fears, hopes and difficulties. Allied to this is vocational guidance. This is an outstanding need particularly of the large group of young people who have not made a vocational adjustment before their breakdown. They are very apt to be quite unrealistic both about their own capacities and the nature of the job they are interested in. The counselor needs a great deal of skill and patience to help them to focus on a practical common sense goal and then to stick with it. When a sound goal has been found, some will need training before they are fitted for it and the Rehabilitation Office is prepared to furnish financial assistance for this, as well as continued counseling and guidance during the training period. And when the client is ready to do the job which he and the counselor have decided is a suitable one, he will need help in finding an opening. The Rehabilitation Office turns for a great deal of help in this part of their responsibility to the State Employment Office, but, at least in the beginning, for a very large number of the mentally handicapped this cannot be delegated. The counselor himself will have to spend much time

looking up and following out job opportunities and will have to do a great deal of employer education.

While it is true that employers are surprisingly ready to take back patients who have been successful with them before breakdown, they are much less ready to accept an unknown from a mental hospital. Even after this resistance is broken down, they are very apt to feel that handling a post-psychotic employee calls for very special skills which they don't have. The counselor must do a great deal of work with employers both in developing job opportunities and in guiding the employer in his handling of the client.

More important than the organization of services are methods and principles, but this is something about which very little can be said at present. Only after experimentation with a considerable number of these patients will any one be in a position to deduce any general principles as to how their needs can best be met. There has been quite a bit of psychiatric theorizing in the past, but very little actual experimentation; but I would like to indicate some of the things that I feel this experimentation should deal with.

First is the relationship of the disease to suitable employment. Rehabilitation counselors feel that they would be greatly helped if the psychiatrist could furnish them with lists of suitable and unsuitable types of employment for different psychiatric diagnoses. This has been done pretty successfully for certain sorts of physical handicaps but we are in no position to furnish such a list for mental illnesses. I have tried to discover some correlation between diagnosis and the various jobs which mental patients have performed successfully and have been able to discover no relationship between the two. I have listed over forty different jobs that patients have worked at successfully after breakdown and recovery and I find myself unable to make even any broad generalization. The arm-chair theorists might say that the schizophrenic ought to be put at work which would keep him out of contact with people, but even this is dubious. There is reason to believe that in many cases the somewhat formal and less intense personal contacts on the job provide a valuable escape from the intense and difficult family relationships and are more helpful than a solitary job which gives altogether too much opportunity to brood over family problems. When very large numbers of post-psychotics have been studied and rehabilitated, it may be possible to draw some general conclusions about suitable and unsuitable employment, but at present not enough intensive work has been done to warrant any such attempt.

A second somewhat related problem for future study is the possibility of providing, through a suitable job, a sublimation of the client's conflicts. Psychiatrists have long held that an important element of success, at least of a spectacular sort, is the sublimation which the individual's activity offered for his conflicts. For example, Napoleon's rise has been related to his conflict over his short stature and it has been suggested that Darwin's interest in developing his theory of natural selection was a sublimation of sexual curiosity. Some of these ideas may seem farfetched but there is real reason to believe that good vocational adjustment is dependent in part on the job's satisfying the individual's unconscious urges. May I give you one illustration which you may consider farfetched, but which nevertheless illustrates what I have in mind? My colleague has reported a case of a young man who, before and during his psychotic upset was greatly troubled with fantasies of knives and of using them to carve up various members of his family. He even bought a long knife and slept with it under his pillow, as if to make his fantasies of mayhem more vivid. This young man had made only a most perfunctory vocational adjustment until after his discharge from the hospital. Since this time he has been in training and employed as a meat cutter and has made a successful adjustment for over a year. Several psychiatrically trained people who have heard the story have suggested that the obvious fact that his vocational choice provided a clear sublimation of his fantasies had something to do with the good adjustment which he has made.

The third problem which needs a great deal of investigation and experiment is how to recognize mental hazards in industry. The physical hazards of various vocations have been very thoroughly studied as has the susceptibility to various hazards of people suffering from different sorts of physical disabilities. As a result, it is possible to steer people with tuberculosis or heart disease or other physical disability away from vocations in which they would be more likely to have a relapse. It is to be hoped that the time will come when we will have a simi-

(*Continued on Page 87, Col. 2*)

Preliminary Steps In The Setting Up of A New Treatment Unit

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The search for space these days is usually a difficult task, and locating a home for any new project is indeed hard. To find adequate, if only temporary, space for a new Cerebral Palsy Center or Curative Workshop is even harder. This is true of hospital units, charitable organizations and welfare clinics, but regardless of difficulties, these projects must be started.

In order to simplify this task, the recognition of certain important factors is imperative. For purposes of this outline, the problem has been separated into three interdependent parts.

1. What are the needs, both basic and supplementary?
2. What are the resources within a given community of hospital organization; public, social and private?
3. What is the basis for the final decisions?

NEEDS

Basic

Consider the first item and determine what are the specific needs. Initially, there must be a consideration of ages and number of patients or clients. Basic requirements are: accessibility for patients, sufficient space not only for treatment but play, storage and waiting room, and adequate lighting, heating, toilet facilities and exits. Not to be overlooked are the safety and fire hazards, both for the normal individual and, far more important, for the person or child with handicaps.

Supplementary

Supplementary requirements include the possibility of parking space for private vehicles, outdoor space for socialization and group activities, expansion possibilities to met the needs of the community and increases in program.

RESOURCES

When we are aware of requirements, then it is time to consider the resources. Depending upon the sponsors, there are several approaches to potential resources. For the new center or workshop that is not directly a part of any hospital, a survey of the community resources is indicated. Working knowledge of the size, population and organization of the community discloses many space possibilities that may be roughly divided into the following groups:

1. Public (schools, playground houses, public buildings, churches).
2. Social (settlement and community houses, YMCA, YWCA, Elks, Rotary, Kiwanis Clubs; women's organizations including the Junior League, professional clubs, sororities, and auxiliaries. Not to be overlooked are Veteran's organizations, i.e. VFW)
3. Commercial (surplus, non-used or dead space in banks, stores, insurance companies and office space. Industrial areas especially small war plants in low, not too large buildings. These may also at one time have housed garages, laundries and cleaning plants.)
4. Residential (homes, apartments with elevators, two- or four-car garages).

Find out through local realtors, clubs, and parent groups what space is available. Try to encourage local volunteers to canvass for these space possibilities.

Ask for help; everyone wants to share in the activities. Not only does this stimulate interest, but it creates *good-will* and encourages future material assistance. Sharing activities brings into the foreground the information as to basic problems; what groups and individuals may be called upon to assist. Presumably the local sponsoring group will want to share in the househunting. The community welfare agencies and interested doctors may assist in many ways; their contacts and associations are established and necessary. Encourage them, it will be of inestimable help. Avoid assuming too many details without assistance.

It is important that the final decision should be made by the director, administrator and therapists, for it must fit their set of working conditions. For example, the group may be able to obtain a portion of an industrial plant with the adequate space, but completely overlook the industrial hazards of machinery, dust, noise

and traffic. Or in a hospital situation, the offered space may have poor ventilation or be located next to a noisy power room.

Therefore check all the possibilities, pick the best location available, then contact the property committee, trustee or board member for the purpose of obtaining this space for occupancy, and together plan a campaign for acquiring this property. A personal introduction to the individual in charge of the property wanted is usually the next step. Such an introduction may be made by an interested, community-minded member of the advisory committee or executive board; these members are usually happy to arrange the needed meeting. With the correct psychological approach, it is easier to obtain the location desired.

HOSPITAL UNIT

If however, the new project is to be located within the hospital area, another approach is indicated. This consists of securing a blueprint and making a physical inspection of the property with the hospital administrator. Here the search is for unused space, which is not always apparent, and which may take real exploration. It includes—

1. Rooms not in use (kitchens, dining halls, board-meeting space, laundry, laboratory area, nurses' home, stock and supply rooms).
2. Semi-closed space within the building proper, (workrooms, garage, sundeck, fuel storage inclosures).
3. Property owned by the hospital but not part of the institution, (resident's and interne's cottages, garages, warehouses, clinics, convalescent units).

In the hospital situation, those trustees most interested in the institution's expansion prove to be the most helpful people with hospital influence and policies. They are also most willing to solve space needs.

Consult with the hospital engineer and maintenance director, and encourage them to help you in your hunt. Such first-hand assistance is most necessary in the development of the project.

CONSIDERATIONS FOR FINAL DECISION

Some guides and cautions[1] essential to all unit planning are as follows:

1. Avoid sharing space with another active

[1] Refer to chart for details.

Ramp added to exit providing for crutch and wheelchair patients. Rail used as walking aid. Note disadvantages: it is uncovered; hazardous in bad weather.

Very adequate entrance, even in poor weather. Doorway is wide, few steps above ground.

program. If exclusive use is not available, the new program will suffer. Equipment will have to be moved constantly; establishment of routine may prove impossible. *It is Far Better to Have Less Satisfactory Space but with Exclusive Use.*

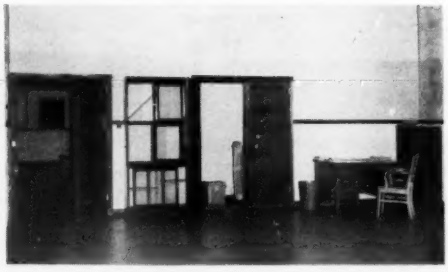
2. Final decisions are not only based on how the area appears initially, but how it may be altered to suit project needs in the future. *Many Somber, Dull Places Could be Transformed with a Coat of Paint, Changes in Lighting Fixtures, and Gay, Bright Decorations. Partitions Can be Erected and Ramps Constructed.*

3. If the physical limitations are kept in mind and an objective but positive attitude is taken, the result will be fewer errors in judgement.[2] A well-kept location, far from public transportation, might be a future possibility, but not in the beginning. *In the Earliest Stages, it is Essential to Simplify Existing Problems Rather Than Adding Transportation Difficulties to Them.*

Temporary space, if satisfactory, should be accepted. Even though the space may not be ideal it will insure the beginning of the program. Every program changes a great deal in the first few months, and each project has particular individual needs. Once the program has started, proper public relations will publicize its needs. As the public becomes educated, the growth of the entire program will follow.

Unsafe egress: too steep, too narrow and area at landing insufficiently open.

Illustrates an undesirable treatment room. Basic space poorly illuminated, on several levels, with many obstructions as a result of sharing location with another program.



Excellent double door, no change in floor level between rooms. Storage space within large treatment area.

[2] Note comparative photographs.

BASIC FACTORS TO CONSIDER

Space Needs	Guides and Caution
Accessibility	Consider the location of the medical advisors. Consider patient's commuting distances and available public transportation. Check the zoning laws for permission to establish a Clinic or Workshop. Do not overlook the influence rainy or windy weather may have on the location, i.e. many children may have to be carried.
Quantity & Arrangement	Minimum of at least three private cubicles (for Physical Therapy, Occupational Therapy, Speech Therapy or vocational testing) to be used for treatment purposes. Some additional provision for play and lounge area (to be use for meetings, library, waiting room) and partitioned office space. If an educational program is included in the plans; special provision for at least one classroom becomes essential. The size of each of the above mentioned areas depends on the type of patient, number in attendance at any one time, variety of treatments anticipated, amount of equipment and supplies needed for regular treatments, and the supplies and equipment to be stored. Adequate storage space for supplies and infrequently used equipment. It is preferable to have this space on the same level with other facilities. If not available, then basement, attic, or outside space is better than none. Treatment areas should be separated from outside entrances, toilets, and waiting room, to provide the quiet essential for adequate treatment. If the division is not present initially, plans for partitions should be made.
Toilet Facilities	For a complete training program either Cerebral Palsy, Orthopedic Clinic, or Curative Workshop with an out-patient group; at least 2 separate toilets, 2 washbowls and one unconnected bathtub should be available. These facilities should be readily accessible and plumbing fixtures well spaced. Additional water outlets and pipes to be tapped are to be desired, ***but not essential.*** Some source of water either in a washtub, sink or cleaning closet should be provided for, in or near the Occupational Therapy room for program needs. One of the wash basins would suffice.
Electricity Lighting	Adequate lighting consists of even, well-lighted areas, minus extra glare or dead spots. In occupational therapy, education, and speed therapy, school lighting (30 foot candles) is essential. Natural light must be supplemented by a school room type of lighting. Consult the lighting engineer of the local electric company. Such consultation service is usually free. If the community branch does not offer such service at all times, the larges district office will help by sending an expert on a consultation visit.
Electric Wiring	Note the adequacy of outlets, wiring, and obtain information on the load capacity of the existing wiring. Plan the number of outlets needed for equipment and electrical appliances to be used. If financially possible, safety lights should be installed over each outlet. All exposed wiring should be clipped or covered by an electrician. Avoid the use of any outlets or appliances near a water tap.

BASIC FACTORS TO CONSIDER (continued)

Heating

Patients should not be overdressed, and during treatment may wear a minimum of clothing. It is most essential to have evenly distributed, moderate heat with good ventilation.

No matter what method is employed, make certain of the resulting temperature.

Take note of draughts from exits, moulding, cellars, etc. Predetermine by asking, how best to eliminate these (screens, insulation, storm door, or any other practical method). Most maintenance men, carpenters, or heating representatives will have the answer.

Entrances and Exits

Check the local safety requirements. At least three means of egress are needed; two of these should be gradual enough for the future addition of ramps.

Ground level or a few steps rise are to be desired for the severely handicapped wheel-chair cases.

Make note of the proportions of stairs and entrances. Stairways should exceed 28" in width. Stair treads should be at least 7" (from back to front). Riser heights not to exceed 4-5". All stairways should have rails.

Steep stairs wtih a ramp added are better than a low but obstructed entrance. Avoid the use of outdoor stairways unless these are covered. Uncovered stairs are hazardous in bad weather, and cannot count as an egress.

The waiting room should be near the most frequently used exit, to simplify the dressing and cleaning problems.

Safety and Fire Hazards

The building and fire inspectors should check on the area before any final decision is made.

Avoid cluttering rooms with excess equipment and furniture. Selective placement of equipment, especially in limited space, insures a greater safety for staff and patients.

Allow sufficient space for wheelchair and crutch travel within the individual rooms of the center. Assure sufficient room for gross activities and the use of large equiqment.

Liability

It is of utmost importance to be fully covered by liability insurance for the patients, their escorts, staff and visitors. This means a total coverage for accident, fire, theft, etc.

Check with the Sponsoring Organization to Determine the Present Liability Policy. If No Policy is in Effect, Check on the Building to be Used. Is it Fully Covered? The Question of Liability Must be Adjusted Before Any Final Arrangements Can be Made.

Does the planned project call for a nurse, or doctor in constant attendance? If not, a staff member should be authorized to give first aid and assistance if it should become necessary. Written permission should be included on the patient's prescription form. This applies especially in cases of seizures, diabetes, cardiacs, and post-operative care.

NOTE: Preliminary considerations necessary prior to actual functioning of the unit have been included. After the project has opened, such items as sources of supplies, maintenance, and the construction of equipment assume greater importance.

Graded Exercise and Work Tolerance

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Sanatorium treatment of tuberculosis dates back to 1840 when Dr. Bodington of England prescribed in the early stages of the disease, good food, fresh air, and donkey riding; in 1859 Herman Brehmer established a sanatorium in Silesia, but in addition to good food, and fresh air, he believed exercise should be graded rather than regulated; today at Niagara Sanatorium graded exercise is prescribed for the tuberculous patient on the day of admission. He is taught how to use his restricted activity to the best advantage to hasten recovery and prevent reactivation of the disease.

For the purpose of graded exercise, progressing to graded work tolerance, the patients are classified in groups, so that the staff members may have an understanding of each patient's physical capacity and clinical progress.

These classifications range from A, strict bed rest, to H, with unlimited work tolerance and cure hours discontinued. In addition to the alphabetical classifications, numbers from 0 to 14 are used to indicate the number of hours the individual patient may spend out of bed. However, the activities listed after each number do not necessarily mean that the patient may engage in all of those activities. For example, a patient may be in Classification D-5, but unless his physician gives him specific permission to go on walks, he is not permitted to do so. The alphabetical classification follows:

CLASSIFICATION OF PATIENTS

Class	*Physical Activities Permitted*	*Extent of Activity*
A	Reading, Radio, Hygiene, Ethics	Strict bed
	With permission	15-30 min. a.m., p.m.
	Needlecraft	
B	All activities above, plus Bed recreation, Chess, Checkers	Bed baths, trays Bathroom in wheelchair
	With permission	In chair 30 min. twice daily
	Free hand drawing, Shorthand Glass painting, Languages Leathercraft, Literature	Tub baths with assistance
		Classes in bed 30-60 min. a.m., p.m.
C	All activities above, plus Filing methods, Bookkeeping Blueprint reading, Fly tying Textile stenciling	Bathroom privileges Tub baths with assistance
	With permission	Social room 15-60 min. 3 times daily
	Sewing and dressmaking, Clay modeling, Book repairing,	Bed or classroom 30-60 min. daily
	Whittling, Caning, Chip carving, Mechanical drawing	Tub baths, dining room In classroom or bed 60 min. daily

Class	*Physical Activities Permitted*	*Extent of Activity*
D	All activities above, plus Telephone technique Dramatics, Debates *With permission* Music (piano), Typing, Ceramics, Bookbinding, Wood carving, Flower gardening, Photography, Table loom weaving	Keep room neat Tub baths, dining room Social room unrestricted Classroom 1-2 hrs. daily Make bed Exercises specified Workshop 1 hr. daily
E	All activities above, plus Medical Secretary Course Nutrition and Cookery Telephone Relief Operator Wood working (light)—Jig saw, Circular saw, Wood turning, Chiseling, Sand papering and Painting	Make bed Exercise specified Work Tolerance 1-2 hours a.m., p.m. Classrooms and Workshop 1-2 hours a.m., p.m.
F	All activities above, plus X-ray filing, Work tolerance, Part-time payroll Wood working (heavy)— Hand saw and hand plane Refinishing furniture Upholstering Wrought iron projects	Exercise specified Work tolerance 2-4 hours a.m., p.m. Cure hours discontinued with permission
G	Activities unlimited Work tolerance, payroll	Unlimited work Cure hours discontinued
H	Patient employee	Employee privileges

The following number classification is not intended to replace the alphabetical classification, but is designed to give information to the patient as well as to the staff concerning the number of hours of activity prescribed for the individual, and, conversely, the number of hours that should be spent in bed rest.

0 Strict bed rest

1 Bathroom privileges only

2 Bathroom privileges
Entertainments and movies

3 Bathroom privileges
Entertainments and movies
Dining room 3 times daily

4 Bathroom privileges
Entertainments and movies
Dining room 3 times daily
Social room 1 hour or classroom 1 hour

5 Dining room 3 times daily
Social room 1-2 hours
and/or
Classrooms 1-2 hours
Walking-exercise outdoors ½ hour to 1 hour

6 Above, plus
Work Tolerance 1 hour—Sewing room, Workshop, Switchboard

7 Work Tolerance 2 hours

8 Work Tolerance 3 hours and discontinue 9 a.m. Cure

9 Work Tolerance 4 hours

10 Work Tolerance 6 hours

12 Discontinue 1-3 p.m. Cure

14 Full time work tolerance

All classifications are dependent upon the physical status of the individual. The suitability of each activity and the period of time to be allotted to it are decided upon by the physician, who considers them in relationship to such factors as the amount of damaged lung tissue, the physical and mental reactions of the patient to treatment, and his resistance to regression. With continued improvement, the type and extent of graded exercises are increased.

All patients on admission are automatically in classification A, and activities requiring no physical exertion are prescribed, such as reading, listening to the radio or to musical recordings on a portable victrola, operated by the occupational therapist. Conversational therapy is prescribed for its value in allaying the fears of future insecurity, and in creating a friendly atmosphere to aid in overcoming the emotional upset which usually occurs in the course of adjustment to sanatorium routine.

With these procedures, the first step is taken toward achieving peace of mind, renewed courage, belief in ultimate recovery, and restoration of self-confidence.

As the patient graduates from classification A to B, and to each succeeding classification until he is discharged, the type of exercise prescribed is not so important as the amount of physical exertion expended, and the satisfaction gained by the individual in terms of his future social, vocational, and economic needs.

To illustrate: E. M., a student in a nearby university, was admitted to the sanatorium on Christmas Eve. To him the future looked very dismal; he became depressed, and soon lost interest in reading and listening to the radio. In the belief that E. M.'s lowered morale was in part due to the interruption of his college career, we contacted his university, where we received a list of subjects to be pursued, and the assurance that the patient would be given college credit for his work upon successfully passing the examinations. Studying for one hour daily, with tutorial instruction weekly, was prescribed while E. was in classification B-1, and gradually increased as his physical condition permitted. As a result, we noticed a very gratifying improvement in E.'s morale and his general attitude towards hospitalization. Gradually, to offset the monotony of continuous study, we shall introduce purposeful diversional activities, such as leathercraft, fly tying, wood carving, or photography.

Group activities, which are also considered as graded activities and work tolerance, with the patients planning, preparing, and actively participating, are of great value in attaining one of our most important objectives—*the social rehabilitation of each individual patient.* Frequently, upon admission, the patient suffers from emotional shock; he may feel that he will not be able to face the problems that will confront him on discharge; he may be concerned with domestic difficulties. As a result, his attitude may be one of resentment, directed toward all within his immediate environment; he may withdraw within himself and resist all efforts to engage him in contact with others.

In such a situation the therapist may use as her initial contact, music and the library. She may later attempt to engage him in small group activities, such as a table of bridge, a small craft group, or a music appreciation group. Gradually the patient may become interested in the larger group entertainments offered by the Occupational Therapy Department or by outside agencies, and in such activities as the Patients' Association and the editing of the monthly magazine. Through his participation in some of these projects, the individual gains not only in his own increased socialization, but in the satisfaction derived from the realization that he is contributing to the welfare and enjoyment of his fellow-patients.

For the individual not interested in further formal education, graduated exercise is prescribed through the media of leathercraft, stenciling, sketching, painting, ceramics, book repairing, or home economics to develop greater efficiency in home management. All of these have, in addition, the possibility of the development of hobbies, prevocational and vocational training.

A typical case of prevocational training developed through graduated exercise is that of J.W., whose interest in needlecraft, while in classification B and C, led to a desire to learn dressmaking, which, in turn, revealed a latent ability to design clothes. Instruction in figure sketching and color was added to aid in developing this talent and was continued until she was discharged and plans were completed for further training in a well-known school of fashion in New York City.

In an institution as small as Niagara Sanatorium, it is not always possible to prescribe a work tolerance activity which will give increased knowledge and skill in the vocation of the individual's choice. However, to estimate his resistance to breakdown from physical effort and emotional upsets, his ability to meet ordinary working conditions, and often as an exploratory technique, all departments of the sanatorium are utilized. These departments are used in the same manner and for the same purposes as is the Occupational Therapy Workshop.

An excellent example of one who found a vocation through exploratory experience is H.K. Her primary interest was laboratory work, but she was placed in the x-ray department because there was no opening in the laboratory at the time her work tolerance was prescribed. She has been able to satisfy her scientific "curiosity" by experiments in x-ray procedures, and, in one instance, by actually effecting a new technique.

To further illustrate: A.N. had been a secretary for an industrial concern and had been a

Red Cross Nurses' Aide during the war. She had always enjoyed copying drawings of advertisements from magazines. The following exploratory opportunities were made available during her graded exercise and work tolerance treatments: commercial art instruction, work as a nurses' aide, and secretarial work in the Medical Records Library. When discharged, A.N. chose employment as secretary to a physician.

With an average hospitalization of two and one-half years for Niagara County patients with collapse therapy, graded exercise and the development of an eight-hour daily work tolerance, with cure hours and sanatorium routine discontinued, it has been possible to follow this type of treatment at Niagara Sanatorium for fifteen years with gratifying results.

To quote our Sanatorium Director, Dr. A. N. Aitken, "If patients can be put on a full work schedule of forty hours a week for a few months before discharge, and are able to play after work without undue fatigue, they should be able to do the same outside."

Presented at Annual Convention of American Occupational Therapy Association, 1948.

Occupational Therapy in Fracture Treatment

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It is a pleasure and indeed an honor to be invited to talk on your program today. We have chosen to deviate a little from the usual routine, and I am afraid that the title of the paper will not quite cover what my remarks will be this afternoon. I wish at first to make a few general observations on the treatment of fractures and then demonstrate to you a few specific problems as have occurred at the Hospital for Special Surgery.

Fractures, as you all know, are a solution in the continuity of a bone. They may be simple, that is, merely across the bone itself without involving other structures; complicated, involving some other structures or extending into a joint; comminuted, broken into more than one fragment; or, compound, protruding through the covering surface of the body, the skin. It is the healing process of a fracture that we are primarily concerned with. Unfortunately, bone is a specialized tissue which heals very slowly and is required for the architectural strength of the body and frequently is subject to quite tremendous stress and strain. It is generally true that satisfactory healing of fractures can be attained only if these fractures are adequately immobilized. Unfortunately, bone is a specialized tissue which heals very slowly and is required for the architectural strength of the body and frequently is subject to quite tremendous stress and strain. It is generally true that satisfactory healing of fractures can be attained only if these fractures are adequately immobilized. Unfortunately, what is good for the fracture is not good for the soft tissues; ligaments, muscles, nerves and vessels that surround it, and it is here that complications and deformities arise. It is here also that occupational therapy finds one of its greatest needs. Frequently, the fracture itself may do considerable damage to the surrounding soft tissues. This will definitely affect later function of the involved area and will probably have some effect on the adjacent joints to the site of fracture. This is seen particularly in the thigh, a region that we will take up a little later. If a wound is compound, namely, open to the elements and to the possibility of infection, the complication and effect to the surrounding articulations may be even greater with the additional possible complication of osteomyelitis. As a general rule the fracture of a shaft of a long bone requires immobilization of the joint above and the joint below in order that this immobilization will be adequate. It

must be remembered, however, that while such a bone is immobilized and healing, that all joints not immobilized must be actively mobilized to prevent the occurrence of unnecessary stiffness and deformity. Thus, in Colles fracture the common fracture about the wrist, stiffness of the shoulder is an all too frequent complication due only to failure of mobilization of the shoulder by active direction. Again, in the same fracture, stiffness of the fingers frequently follows. While on the subject, it should be noted that stiffness occurs in the fingers more easily than any other joints. Fingers should never be immobilized more than 3 weeks if there is any way out of so doing. Long immobilization will almost certainly produce permanent loss of motion in the small but complicated joints. Occupational therapy may be very important during the phase of immobilization to keep other joints mobilized. Constant efforts are being made to allow greater mobility at all times to areas of injury. This cannot be done at the risk of loss of immobilization of the fracture, but the use of skeletal fixation of various means is a help at reducing the immobility of joints to a minimum. The methods of skeletal fixation are, primarily, the use of plates on the bone, which generally speaking, still require the use of external splint fixation, especially the use of plaster of Paris. Secondly, external pin fixation of bone as has been widely advocated and advertised especially in the lay press, and, thirdly, in more recent use of intraskeletal fixation, such as the Kuntschner nail, which I will now demonstrate.

The latter two of these means have received a good deal of publicity during and since the war and there is often the question put to the doctor as to why this means is not more often used by him. There are certain men who use these methods almost exclusively but there are those of us who feel, and I think it includes most surgeons that they have gone overboard in enthusiasm for a more complicated way of treating fractures. We feel that it is necessary to know how to use this equipment and to use on the specially indicated cases as may be shown. It is, however, a serious step to convert a simple, uncomplicated fracture into a compound one in plating a foreign material into it. The danger of infection, even in the presence of the chemotherapeutic agents of today, is not to be minimized, and to say that these methods always succeed is, of course, beyond the truth. They have their inherent risks, and for the great percentage of fractures, the simple use of plaster of Paris splints and proper methods of reduction will still give the best results, if used intelligently and used with proper supervision and care for the soft tissues about the joints. That other means, such as those mentioned, may have a very important place, is not denied, and in fact, is confirmed by the few patients I will present later. However, the value of the conservative outlook in the treatment of fractures cannot be overestimated for as a general rule, there is much more difficulty encountered following the more radical methods of open surgery than that of manipulation and the use of plaster.

I would like now to show you a few individual problems scattered at random throughout the body, involving mostly, the elbow and knee. I will not discuss the hand at a session like this as it is a problem completely unto itself, and I will ask Miss Brokaw to discuss some of the problems these have presented to the occupational therapist in their treatment.

Now, in conclusion, if there is one lesson to be learned in our supervision of fractures, it is the importance of generalized mobilization. We cannot mobilize the area affected until the healing of bone has made it rigid enough to support stress and strain without danger of refracture. Movement of bone through an unhealed callus produces fracture lines which will eventually cause non union. We can, however, make every effort to keep the rest of the body in complete tone and trim to make sure that all surrounding joints that can be mobilized are mobilized; that they have normal muscle power; that they can use this muscle power for a certainty.

In the upper extremity it is of the utmost importance to see that the fingers can still be moved and to keep the quality of the movement in terms of strength at its highest peak. It is here that occupational therapy can play its greatest role in the prevention of disability. To do so, in my opinion, it must become part of an overall program of rehabilitation, which though it must seem diversional, must actually be functional in its every move.

Read at the Annual Convention of the American Occupational Therapy Association, 1948.

NATIONALLY SPEAKING

From the President

I have been prompted to take a good straight look at the progress of the American Occupational Therapy Association as we near the end of my first three-year term as your president. It was hard going, that first year, with the knowledge that our Veteran Executive Secretary would resign and must be replaced within the year, that a new Journal must be established, and a permanent Educational Field Secretary must be located at the termination of Miss Hurt's one year appointment. Perhaps worst of all was the fact that there was not sufficient income in sight to maintain the office at its then present level, much less increase it to meet the rising costs of operation.

But somehow your officers, (especially the Treasurer) and your Board of Management, figured and counted, scrimped and squeezed, taking a little from one place and padding another where it was most needed, until we were convinced that nothing could keep us afloat but to raise the dues and registration fees to meet operation expenses. Through the interpretation of the delegates to the membership of our state associations the need for financial assistance was broadcast, including the provision that all dues and registration fees be paid by January 31st of each year.

The response has been most gratifying. It is a great comfort to realize for the first time in the history of our association that on the first year we have a budget that assures our national office personnel that they will receive their salary "even as you and I". To review our financial reports of February 28, 1948 and now as of the same date 1949 proves that the large majority of O.T.'s maintain an interest and loyalty to our organized effort for progress in Occupational Therapy. On March 1st 2467 of our members have paid their membership dues and 2515 have paid registration fees. These figures show, however, that of our total membership more than 500 members are still unaccounted for and in arrears. The deadline was January 31st — remember! At any rate the national Officers, Board, and Staff, thank you most sincerely and trust that those who have delayed or forgotten ot pay up before January 31st will promptly realize the importance of re-establishing their status as registered O.T.'s in good standing.

Now to recount our blessings without a repetition of statistical reports which have come to you regularly through official reports from the executive director, the Treasurer, the Board, and our national committee:

In the reorganization of the national office we were particularly fortunate in securing the services of an Executive Director and Educational Field Secretary to efficiently represent Occupational Therapy in any quarter, in organization, in education, or in the field. They have the ability to handle any situation or any problem with which we are confronted. They have retrenched when we were in dire financial straights and have the capacity to expand and extend our program to the limit of our resources, whatever they may be.

Our standing committee reports will show you the benefits of the coordination of committee activities through your national office. There are nearly 100 of our leading members active on national committees. Two new special committees have been appointed on important study projects — that of *The Establishment and Operation of Occupational Therapy Departments* headed by Miss Marguerite Abbott, and a *Constitution Committee* with Miss Martha Jackson, as chairman, to study the revision of our outmoded constitution.

Here I am reminded of a request that was made by the Board of Management at the New York conference meeting in September. The State Associations were requested through the House of Delegates to mail to me a list of members desirous of serving on national committees. To date I have received only four lists from the 28 states associations. We need the stimulation of new personalities and ideas so please send your suggestions along with the preferences for committee participation.

The further processing and analysis of our registration examination has won wide acclaim and added professional prestige for occupa-

tional therapy in educational schools and among the allied medical professions.

The Kellogg Foundation Grant of $10,000 for this year and $8,000 for next year for the continued support of our Educational program was reported to you in the last January issue. This generous extension was made solely on the basis of the excellent showing our Education Office had made and the presentation of our sound program over a three-year period. A word of caution, though, is imperative for the future! The association and schools must find ways and means to carry the full financial burden of educational advancement by the year 1951.

The success of our Polio Committee in obtaining twelve scholarships for graduate study through cooperation with the National Foundation for Infantile Paralysis gives opportunity to the practicing therapist in the field of physical disabilities. Many thanks to Miss Hurt, the members of her committee, and Miss Katherine Worthingham, for their efforts in this direction. Also, our appreciation goes to the University of Southern California for setting up the course to be given this summer.

It is likewise anticipated that opportunity for special study in the field of poliomyelitis may be forthcoming. Through the approval of the National Foundation for Infantile Paralysis, registered occupational therapists may be included in courses given at Warm Springs Foundation. As soon as final details and regulations of these scholarship grants are completed, members will be notified.

Miss West and a special committee are now at work on a project through which we hope to obtain graduate scholarships in the field of Psychiatry. It is too early to report specific progress on this plan but it sounds exciting and encouraging.

Permanent Conference Committee. The function of this committee for two years shows steady progress. Do you know that for the first time our annual conference showed a profit for the Association. Much credit is due the Local Conference Committees and the Institute Committee in New York. It is expected that a plan for commercial exhibits at our annual meeting may be made a regular and a profitable source of income.

The Journal (now our own property). We are certain that AJOT has been a source of great pride, satisfaction, and much usefulness to all of you. Hearty thanks is due to its originator and first editor Charlotte Bone, and best wishes for its continued success goes to Mrs. Murphy, the new editor. You are urged to help to make your own magazine outstanding by contributing and suggesting what you do, what you know, and what you want. If you help — you'll get it.

Clinical Research and Service Committee. We are looking forward to the publication of the manual of adapted equipment. The excellent material compiled by Carlotta Welles and her committee makes us anxious for the completion of this volume. Complications have arisen in publication matters but we know it's worth waiting for.

The Rules and Procedure Committee with Sister Jean Marie Bonnett as chairman, has made an exhaustive analysis of the formation and operational procedures of our standing and special committees with a view to more closely integrating and recording the results. Some recommendations of this committee have already been accepted and improvement in the coordination of committee activities through our national office is evident. It is expected that ultimately we may have a manual of procedures as a guide to all committee functions.

Public Relations is a constant daily performance in the national office in addition to the many contacts with allied agencies which are maintained by our professional staff. Detailed reports of the activities cannot be given adequate explanation here but will come to you later in our staff reports. The most helpful aid to the members in public relations will be a new brochure which is nearing completion now and should be released before April 1st.

Miss Frances Helmig of the Rochester Curative Workshop has accepted the chairmanship of the Nominating Committee for this year. A list of the other members of this committee will reach you as soon as possible through your state associations, with instructions for your consideration.

Now with spring in the air, it's time to plan ahead for vacations. In doing so we urge you to figure on routing yourself via Detroit with a stop over for the Conference August 23-25th. A fine program, something new in exhibits — besides the Institute which we know you won't want to miss are all well under way. Besides

the Michigan Association keep hinting about a very good time. This is a good central location so let's try to beat last year's, best yet, record of attendance.

From the Executive Director

One of the main purposes for organizing state occupational therapy associations was to help bring the AOTA closer to the membership. Principally, this occurs through the House of Delegates — a part of the national association which is made up of representatives of the state groups. Acting as a discussion group, clearing house, or sounding board, the House is the means through which the membership expresses its collective opinion. Although it has neither legislative nor executive powers, this body is usually instrumental in shaping the policies formally voted by the Board of Management.

In addition, state associations have as one of their chief benefits the provision of a means for gathering local groups together. Here, interests may range from social fellowship to purely professional activities and consequently have varying degrees of value both to the individual member and to the profession as a whole.

To the latter aspect — the professional value of state associations — we must look for the future growth and development of occupational therapy. Your actual monetary contributions as members of the national organization finance activities with which you are all familiar. (AJOT, Vol. II, No. 5, pp. 303-306 and No. 6, pp. 370-373.) The work of officers, board members, and association committee has increased our professional effectiveness and made possible our achievements to date. The efforts of many others must however be added in order to meet increasing demands and responsibilities. For this purpose, the large and essentially untapped work potential in state associations has to be organized and drawn upon for this purpose.

The larger state organizations, particularly those in metropolitan areas, have long been active in various types of professional endeavor. Many of them publish newsletters or bulletins, hold joint meetings with allied groups, conduct educational institutes, foster interest in community activities, etc. These are all worthy and rewarding activities which contribute to the growth of the individual member and to the association concerned. State organization programs could, however, be of even broader and more lasting value if devoted to the needs of the profession as a whole.

Inumerable ideas for projects have been suggested by members at various times in the past as pertinent to the further development of occupational therapy. For example: basic standards should be available for hospital floor plans, equipment and supply lists, personnel policies, treatment fee scales and average case loads; national problems of publicity and recruitment could be more effectively handled through contacts with vocational guidance counselors in high schools, colleges, and universities; exhibits of occupational therapy in specific disability fields could be prepared and more widely shown at local medical and allied professional meetings; slides and film strips could be produced to fill a great need in visual education; professional writing and research might be extended by group work beyond what can be accomplished by individuals.

Some of the above proposals are actually a part of current studies of the national association, its committee, and/or state associations; some could be assigned as small, complete subprojects; some will involve detailed and long-term work; and some will undoubtedly lead to further studies.

It is apparent, then, that there is no "unemployment problem" in the profession. That most of us are already doing much more than one job is also an accepted fact. Properly utilized, the work potential previously mentioned can help to relieve this burden of work to be accomplished. It includes the 38% of our total OTR population who are now inactive. (AJOT, Vol. III, No. 1, p. 32.) The largest number of these are married and cannot devote full time to a regular job. Their continued interest and help with general professional problems could, however, be elicited on a wider basis than is now the case.

There is a reservoir of ability in art, speaking, writing and other areas in state groups which in many cases needs only stimulation, organization and direction to make it work for the profession as a whole. In past years, state associations have made their contribution to the national organization through a check. These have always been most welcome and have aided the AOTA in its varied activities. The

idea of making a "service" contribution will also appeal to some groups.

This does not mean to suggest that state groups should forego all distinctly local interests for problems of national import. Such would only defeat the major purpose for which these groups are organized. It is possible to do both successfully.

If the thought of undertaking projects in state groups appeals to you as individuals, will you discuss it in your next local meeting and let us have your reaction or, better still, a definite proposal? We would like to compile a list of projects with brief outlines of objective, value, approach, method and estimated cost for each in order to avoid duplication of effort. Some groups will have ideas of their own about projects in which they would be interested while others might prefer to undertake one of the many pending studies registered here.

In the next issue, this column will be devoted to outlining a number of projects whose development should be of interest to state groups and of significance both locally and nationally. The list will be incomplete and tentative only, but it should serve as a starting point. If you have comments, additions or deletions to propose, please let us have your ideas *immediately*. (The deadline for the next issue will be May 1.)

From the Educational Field Secretary

In the January-February issue of the American Journal of Occupational Therapy we gave a brief progress report on the various projects of the educational research program. Since then, work on these studies have continued.

We are pleased to announce that one of the projects, construction of a Performance Report Form, has been completed, and that this material will soon be sent out to the directors of all occupational therapy departments employing first-year occupational therapists. At this time, we should like to tell you in greater detail than has been possible before, about the purpose of the form, how it was developed, and how it will be used.

Correlation data gathered thus far on the present registration examination and academic grades indicate that the examination procedure is a consistent and reliable measure of the student's *preparation* for her future work. The true test of the quality of the graduate's training, however, lies in her subsequent *effectiveness* as an occupational therapist. Until now, there has been no means of procuring objective evidence that the registration examination can predict performance on the job. The Performance Report Form will be used to establish this criterion by furnishing data on the job performance of all therapists who have taken, and will take, the new type of AOTA registration examination and who have worked as occupational therapists for at least one year. A comparison will then be made between the therapist's rating on the registration examination and her rating on the job, and conclusions on the performance-predicting capacity of the examination can thus be drawn.

The form was constructed by the Education Office in cooperation with a large group of therapists from the clinical field. This working committee first determined the six major components of an occupational therapist's job. These are: conduct of a therapeutic program, administration of the department, creativeness in every aspect of the job, conduct of public and professional relationships, execution of a training program, and professional ethics. The committee then determined the traits which the occupational therapist must demonstrate in order to be successful in these six areas. A total of 14 independent traits (such as cooperation, industry, initiative) were established and defined in terms of the occupational therapist's first-year performance. These definitions appear on the form for the guidance of the rater. Each trait was subsequently broken down into all its elements of performance. From these, statements describing behavior typical of the occupational therapist were derived. There are 80 of these, distributed in groups of 5, 6, or 7 over the 14 traits. It is on these statements that the therapist will actually be rated.

The new instrument permits a rater to indicate whether or not, and to what extent, the therapist has demonstrated the various behavioral aspects of the 14 traits. In order to protect the therapist who has not had an opportunity to manifest a particular trait nor to be observed in it, an NA column (not applicable) has been added for the rater's use. The scoring system to be used will assign a value of either plus, zero, or minus to each statement checked. In addition to being rated on the 14 traits, an

evaluation will be made of the therapist's overall effectiveness in the six major components of the job. Total scores thus obtained will reveal varying degrees of job performance by first-year therapists.

The form is to be completed by the ratee's immediate superior. Ratings obtained will be used for the stated research purpose only and will not reflect in any way on a therapist's present position or future status.

The workability of the form has been tested and has been approved for use by the AOTA Education Committee. We believe that it will provide a necessary external and major criterion for evaluating the registration examination.

You may soon be called upon to complete the form for one or several of your staff members. May we ask you to give your full cooperation on this project. We all want the registration examination to be as practical and as fair to the student as possible. Your assistance will help accomplish this goal.

EDITORIAL

GERIATRICS

A matter of great sociological importance is confronting our country today, namely, the problem of the aged, many of whom are chronically ill. Modern homes are not equipped to take care of these cases and their numbers are increasing steadily because people are living longer.

The result is that most cases become the responsibility of society confronted with a lack of adequate facilities. Many of these people could be helped to return to the point of self-sufficiency with adequate care and guidance.

The medical profession is aware of this problem as evidenced by the increasing number of physicians specializing in *Geriatrics*. Are we as occupational therapists also facing our problem?

The greatest need of these patients is an interest and encouragement to make the necessary attempt to restore lost abilities. Their need is psychological as well as physical. Occupational therapists are ideally trained to help these people but few therapists want to work with this group. Are we not ignoring a hugh field for development but letting our prejudices of the *"old"* influence our expansion?

Agencies are available in every community to finance the care of these people and the local occupational therapy association should propose a suitable therapy program that would adequately serve the community and be available to all interested physicians.

Local and state association groups should initiate more facilities rather than wait for the physician to request a service. He won't unless he is assured it is available to his patient.

Our slow growth is not so much due to the slow education of the doctors as to a lack of enterprise among ourselves. Have we done all we can to promote a community request for our services? Evidently not as shown by the few demands for effective occupational therapy treatment among geriatrics.

SOCIALIZED MEDICINE

As medical assistant and as a citizen of the United States, all occupational therapists are doubly interested in the controversy that will arise in Congress about Socialized Medicine. Have you ever thought of the effect it will have on you? Will it better your position or will it be more constricting?

As educated, informed, and professional people, give this matter your serious consideration, and then inform your Representative and Senator of your views so that they may be better informed as to the views of everyone concerned before it is necessary for them to vote.

(*Continued from Page 72*)

lar list of hazards to mental health to which the post-psychotic ought not to be subjected. These are to be sought, not as much in the sort of work in which the individual is engaged, as in the social organization of the business, and this is of importance not only for the mentally handicapped but for the normal worker as well. If Rehabilitation counselors and psychiatrists will study this problem together, in connection with their cases, they should in time accumulate information which should be of great value to all employees, not simply their own clients.

PEOPLE YOU SHOULD KNOW

GOLDWIN WILLIAM HOWLAND, M.D.

ELSIE JACKES, O.T.R.
Director of Occupational Therapy
Toronto General Hospital

Goldwin William Howland, B.A., M.D., L.R.C.P., M.R.C.S., F.R.C.P. (Canada), F.R.C.P. (London), retired from the Presidency of the Canadian Association of Occupational Therapy at the recent annual meeting in November, 1948. He had been its presiding officer for twenty-two consecutive years — in fact, since the formation of the Dominion association in 1926.

Dr. Howland was born in Toronto, Ontario, son of William Holmes Howland (former mayor of Toronto) and Laura Edith (Chipman) Howland of St. Stephen; grandson of Sir William P. Howland (former Lieut-Governor of Ontario). He married Margaret Christian Carrington, daughter of William C. Carrington, (brother of Major-General Sir Frederick C. Carrington), September 11, 1906.

His early education was rceeived at Jarvis Collegiate; following which he graduated from the University of Toronto in Arts as the McMurrich medallist, and in Medicine in 1900 as Silver Medallist. During the course of these academic years he became a member of the Delta Upsilon and Phi Chi societies, Honor Fraternities of the University of Toronto.

He continued his studies in London and Berlin, later receiving the appointments of Clinical Assistant, Queen Square, London, England, 1902-3, and Registrar, National Hospital, Queen Square, London. He has the distinction of being the first Consulting Neurologist in Canada, and is a former member of the American Neurological Association. In 1932, he was Vice-President of the Neurological Section, of the British Medical Association. As author of many medical articles, in medical journals of different countries of the world, he has made, over a period of many years, a valuable contribution to the literature of the Medical profession. He has lectured considerably in Ontario, and on occasions in the United States.

During the first World War, he served in the Royal Canadian Army Medical Corps as Major, in 1918-19. In 1923, the members of the Ontario Society of Occupational Therapy, the original professional organization of Canadian therapists, conferred a Life Membership on Dr. Howland, for his indefatigable efforts in assisting in the promotion of their profession. He is also honoured with a Life Membership of the American Occupational Therapy Association.

Dr. Howland's interest in occupational therapy did not commence when he was first elected to the Presidency of the Canadian Association of Occupational Therapy. Rather, it began with his efforts to establish an Occupational Therapy department in the Toronto General Hospital. He was chiefly responsible in achieving this; consequently, when the department opened in the summer of 1919, his accomplishment distinguished this hospital by making it the first general hospital to have this service added to the personnel. Since then his interest has never flagged. Instead, it has been the principal stimulus which has spurred Canadian therapists on, through the past thirty years, to their achievements of to-day. Dr. Howland and the

history of occupational therapy in Canada are indissolubly linked together.

On February 1, 1921, on the invitation of the Executive of the Ontario Society of Occupational Therapy, Dr. Howland addressed the members. At this meeting, the fourth held by the society, he stressed the important part which occupational therapy could take in the treatment and rehabilitation of both medical and surgical patients. He advanced progressive ideas for therapeutic occupations. He also advised the members to broaden their horizon beyond the hospitalized patient, by establishing occupational therapy clinics, which would serve indigent patients as well as those who could pay for their treatments. At the same time, he pointed out the importance of definite attributes which were appropriate and essential in a competent therapist. In stressing this, he has helped to build the personalities of the therapists; as in striving for this standard of perfection they have profited by his advice.

In April, 1921, the members of the Ontario Society of Occupational Therapy held a Drawing Room meeting at Government House. At this meeting an Honorary Advisory Board was formed. Dr. Alexander Primrose, Dean of the Faculty of Medicine at that time, was elected chairman of this board which included Dr. Howland as one of the original members. Before the year was ended, as an active member of the Investigation Committee, he had made a survey of the need for occupational therapy in all fields of medicine and surgery, not omitting outdoor clinics. While considering the latter, it was natural for Dr. Howland's imagination to soar to new heights with the idea of a central workshop and headquarters. This idea, he immediately incorporated into his plan for future expansion.

By February of the following year, he was urging the advisory board to commence correspondence with the Senate of the University of Toronto regarding the establishment of a new course in occupational therapy. He recommended that this course should cover two academic years. At the same time he was striving for the central workshop, and with the help of his Finance Committee sent out 2,500 letters, inviting subscriptions to finance this objective. These approaches met with a very generous response, making it possible to open the workshop in October of the same year. Letters were then sent to the members of the medical profession advising them of this new service; and soon it was successfully operating for the patients referred from the physicians and surgeons of the community; and for others from the Workmen's Compensation Board. This new venture necessitated the formation of a board of management for the workshop, and by the end of one year this undertaking had expanded to a point where it was imperative to seek more spacious accommodation. This was done; and the workshop was moved to larger quarters.

It would seem that by this time occupational therapy in Canada was forging ahead on its own momentum, make no mistake. This was not the case. The accelerating influence behind all this progression was Dr. Howland, and the Honorary Advisory Board. At this time, in 1923, he was seeking a means of enlarging the income of the workshop, in order to accommodate more patients. To expedite this ambition he was instrumental in the formation of a bursary committee. The duties of this committee involved the soliciting of bursaries to finance the treatment of patients who were unable to pay for this service. It was composed of doctors and laymen, and later developed into the Women's Auxiliary Committee, with the workshop as their feature interest. Interesting local business men for their help in financing a more suitable building for expansion of the workshop, was another obligation assumed by this committee; and in June 1925, the workshop was moved to the present location at 331 Bloor St. West, largely through the kindness of Mr. John Lash.

Following this achievement, Dr. Howland again turned his attention toward the establishment of the new course in Occupational Therapy. As Chairman of the first Educational Committee and representative of the Advisory Board, he convinced the Senate of the University of the urgency of this move, by pointing out the increasing demand for occupational therapy and the existing shortage of therapists to meet this emergency. In consequence, the University of Toronto established a new two-years' course; and the first class was enrolled in the autumn of 1926. This was an eventful year for Canadian therapists, as it also saw the formation of their Dominion association, which Dr. Howland had been advocating for three

years. It also brought them outstanding leadership, when he honoured the association by accepting the first presidency of the new Canadian Association of Occupational Therapy.

His ambition recognized no boundary; and soon the annual meetings developed into annual conventions of several days duration. The first overseas development occurred in 1933. Following a request from Colonel Cunningham, Medical Director of the Astley Ainslie Hospital, a Canadian therapist was loaned to organize an occupational therapy department in his hospital in Edinburgh, Scotland. By 1934, the registration of graduate therapists had increased to a gratifying number, and Dr. Howland pointed out that therapists should now have acquired enough practical experience to be able to submit material for a professional journal of their own editing. This led to the formation of an Editorial Committee; and in September 1934 the first number of the Canadian Journal of Occupational Therapy was published. This was another outstanding year, under the leadership of Dr. Howland. It also saw the completion of the Constitution, when the Canadian Association of Occupational Therapy was granted a Dominion charter. This charter gave occupational therapists the sole right in Canada, to the title of Occupational Therapist.

From 1934 on, the succession of outstanding events was rapid. In 1935 the Canadian Association was re-organized to include a Board of Management, Provincial Representatives, and an Honorary Advisory Council. In 1937, the Montreal Occupational Therapy Centre was established and the Quebec Society of Occupational Therapy was formed; and in 1938, Dr. Howland secured the first grant ($5,000) from the Provincial Government of Ontario for the development of occupational therapy within the Province. By 1939, when occupational therapy was expanding so extensively in all its fields, Dr. Howland had appealed to the Board, asking approval of the appointment of a Consultant Secretary to deal with this accumulating expansion. When this request was sanctioned, an appointment was made in July of that year.

During the wear years his efforts on behalf of the Association were unremitting. Following the declaration of war, and with the permission of the Board, he offered the services of the Association in any capacity in which they could be used, to the Prime Minister of Canada, the Minister of National Health, and the Minister of Health for Ontario. He was convinced that occupational therapists had much to contribute toward the rehabilitation of the casualties of the war. This conviction was confirmed when he received letters from the British War Office and the Department of Health for Scotland, asking for five therapists to serve Overseas. Five therapists were chosen for this distinction; and the Canadian Red Cross Society arranged the financing of their transportation to Great Britain. On further requests, two more therapists were sent to Scotland; and again three more to staff the Occupational Therapy Department in the Astley Ainslie Hospital in Edinburgh, and to carry on the two-years' course, at that hospital.

Although he finally achieved the appointment of a therapist to organize occupational therapy in Canadian hospitals of the Department of Pensions and National Health, Dr. Howland still was not satisfied. He continued his extensive correspondence with the chief of the Department of Defence, and finally, in November 1943, his dream was realized. Brigadier Meakins announced the decision of the Department of Defence to enlist occupational therapists in the Royal Canadian Army Medical Corps, for service in Canada and Overseas. Service in the Royal Canadian Navy followed soon after this announcement; and increasing numbers were absorbed by the Department of Veterans' Affairs, for hospitals across Canada. Occupational Therapy was now launched, and accepted in its proper status as an adjunct to medical treatment.

Canadian occupational therapists had long felt deeply indebted to Dr. Howland for all his efforts on their behalf; and they searched for some way to signify their appreciation. They finally made their decision, and established the Goldwin W. Howland Scholarship, for post graduate study. This gesture, they hoped, would in some measure express their gratefulness, and at the same time perpetuate the memory of their indebtedness. During the concluding two years of his tenure of office, he awarded this scholarship to two therapists; one of whom chose to continue her studies at the Childrens' Rehabilitation Institute, in Cockeysville, Md., and the other at the Massachusetts General Hospital. The selections made by these

therapists were most opportune, as Dr. Howland is an enthusiastic advocate of reciprocity and friendly rapport with the sister occupational therapists of the United States.

Before his retirement, he entered into discussions with the present Dean of the Faculty of Medicine regarding more adequate instruction for Medical students on the understanding of the use of occupational therapy. He also urged the establishment of more courses in occupational therapy, in other parts of Canada. He saw the expansion of all fields of occupational therapy, including one of the latest, Geriatrics. The organization of the British Columbia Society of Occupational Therapy was also concluded in this period. His final accomplishment was the revision of the Constitution of the Canadian association. This was ratified at the last annual meeting, and so left his 'house in order' for his successor.

Despite the demands of his private practice, his teaching program for the University of Toronto, and his clinical work at the Toronto General Hospital, he found time to do all these things for the advancement of occupational therapy. From the time he first addressed the professional group of therapists to the day of his retirement, he never ceased to drive for new outlets for their usefulness.

While the foregoing information outlines Dr. Howland's ability for organization and accomplishment, it does not tell of his many personal gestures of generosity; nor would he wish them to be mentioned. However, it does not stretch the imagination to assume that it was he who presented the Ontario Society with their first Bursary, or he who stood behind the therapists on the occasion of one Theatre Night in aid of the workshop, which was a financial disappointment. With no intention of stressing his generosity to the Association, it should be remembered that he was their staunchest friend, and keenest stimulus. It was his keen sense of humour, enthusiasm and optimism, with his ability to inspire the same qualities in others, which surmounted the discouraging periods which are the inheritance of every new profession. He had an objective attitude toward the goal which he set for the Association, and refused to consider defeat when any obstacle was presented.

Canadian occupational therapists, including those who are not yet enrolled, will forever owe a debt of gratitude to him, for his untiring efforts in the directing of their Association, and in the promotion of their profession in Canada. Is it any wonder that they have such a warm feeling of affection and gratefulness in their hearts, for their Dr. Howland?

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Attend the 1949 Annual Convention at the Book-Cadillac Hotel, Detroit, Michigan, August 23-25.

SCHOOL SECTION

RICHMOND PROFESSIONAL INSTITUTE OF THE COLLEGE OF WILLIAM AND MARY

DEPARTMENT OF OCCUPATIONAL THERAPY

The School of Occupational Therapy at the Richmond Professional Institute is the only school of occupational therapy in the South.

Established for eight years, it has over one hundred graduates now practicing occupational therapy in twenty-seven states from New Hampshire to Florida and from Texas to California. This includes one graduate in Hawaii (2nd Lt. Martha Rinebolt), and one in Germany. In 1942, when the school was established, there were five occupational therapists in Virginia, and there are now about forty occupational therapists practicing throughout the state.

The School of Occupational Therapy was established in September, 1942, under the capable direction of Miss Sue P. Hurt, O.T.R., a native of Richmond, a graduate of the Philadelphia School of Occupational Therapy and a leader in the professional field. The Department of Occupational Therapy was so firmly established within two years that in 1944-45 it was one of the eight schools chosen by the U. S. Army Medical Department to train occupational therapy students in a War Emergency Course.

Miss Hurt resigned as Director in 1946 and Miss Helen Freas, O.T.R., one of the first graduates of the Occupational Therapy School agreed to be Acting Director until the next full time Director was appointed. In September, 1948, Miss H. Elizabeth Messick, O.T.R., was named Director and assisted in a consultant capacity until March 1, 1949, when she joined the faculty as full time Director of the School of Occupational Therapy. Miss Messick has had broad experience in occupational therapy both with the military and in the civilian field and is currently consultant to many national programs.

The Richmond Professional Institute of the College of William and Mary consists of a group of professional schools and departments to which has been added a junior college of liberal arts and sciences. The professional schools and departments offer two, three, and four-year programs of study open to high school graduates leading to certificates or professional degrees. Four of the schools also offer one or two-year programs for college graduates.

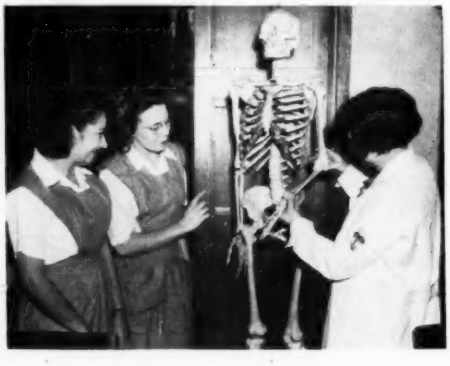
This technical college which combines both professional and vocational preparation uniquely with general education had its beginning in 1917 when the Richmond School of Social Work and Public Health was established by a board of private citizens. In 1920 the Institute became affiliated with the College of William and Mary, and in 1925 it became a definite part of the college.

Although the College of William and Mary is the second oldest college in the United States, the Richmond Professional Institute is the youngest institution of higher learning in the state of Virginia. The parent institution (The College of William and Mary) is a liberal arts college located at Williamsburg, while Richmond Professional Institute, is, as its name implies, a professional institute located in the central section of historic Richmond. In the field of liberal arts and sciences it goes no farther than the sophomore year, yet it does, in its own special fields of professional and vocational education, offer a wide variety of programs extending not only through the usual four college years, but, in certain fields, into

one or two years of graduate-professional work.

Dean Henry H. Hibbs, who has been Dean of Richmond Professional Institute since it was founded has had a keen interest in Occupational Therapy since 1918 when he recommended in the original organization of Richmond Professional Institute that the development of a School of Occupational Therapy ought to be considered. The present high professional standards of the school are due in no small measure to the sustained interest of Dr. Hibbs in the Department of Occupational Therapy.

Among the courses offered by the Department of Occupational Therapy are the Advanced Standing Course open to college graduates and the Certificate Course open to students who have had one or more years of college. These students may receive their degree in psychology. The psychology courses offered provide an excellent background for occupational therapy.



Students in Anatomy Class

The clinical affiliation, an important phase of the training of occupational therapy students, is of ten months duration and covers the major fields of Neuropsychiatry, Physical Disabilities, Tuberculosis and Pediatrics.

The course is affiliated with the Medical College of Virginia, also located in Richmond and many of the medical lectures are given jointly with the physical therapy students of the Medical College's Physical Therapy Course. This year a series of lectures on Physical Therapy for occupational therapy students and on Occupational Therapy for physical therapy students will be given simultaneously and then the two groups combined for final lectures and discussion on the coordination of the two types of treatment in the applicable conditions.

In interesting prospective students it is anticipated that much emphasis will be placed on the Advanced Standing Course in order that a greater number of occupational therapists may be made available sooner for the increasing demands for trained people.

EVENTS CALENDAR

MAY 18-21
Association for Physical and Mental Rehabilitation, Hotel New Yorker, New York City

MAY 23-27
American Psychiatric Association, Windsor Hotel, Montreal, Canada

MAY 28-30
Western International Conference of Occupational and Physical Therapy, Vancouver, B. C.

MAY 30-JUNE 3
International Congress on Rheumatic Diseases, New York City

JUNE 19-24
American Physical Therapy Association, Copley Plaza Hotel, Boston, Massachusetts

JULY 25-AUGUST 12
Cerebral Palsy Workshop, Syracuse University, Syracuse, New York

AUGUST 20-22
House of Delegates, Board of Management, and Committee meetings of American Occupational Therapy Association, Hotel Book-Cadillac, Detroit, Michigan

AUGUST 23-25
Convention of American Occupational Therapy Association, Hotel Book-Cadillac, Detroit, Michigan

AUGUST 26-27
Institute of American Occupational Therapy Association, Hotel Book-Cadillac, Detroit, Michigan

FEATURED O.T. DEPARTMENTS

OCCUPATIONAL THERAPY AT THE QUEEN'S HOSPITAL

Honolulu, T. H.

Esther Pyun, O.T.R.
Director of Occupational Therapy

The Queen's Hospital was founded in 1859 by King Kamehameha IV and Queen Emma, the latter in whose honor the hospital was named. Their purposes have been fully recognized through the generous support of public-minded citizens and doctors in the community.

The Queen's is a 400-bed hospital. It is like any modern hospital which provides nursing

Group Activity for Socialization

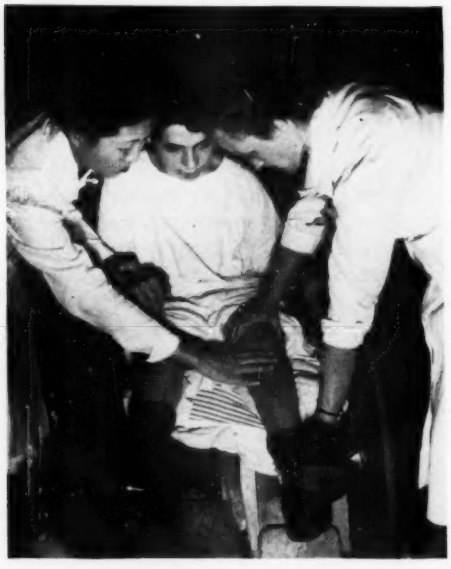
care for the sick and injured, where the latest methods of treatment and diagnosis of disease are available and which serves as an educational center for doctors, nurses, technicians and others who are interested in community welfare and health. The Hospital has in every way met the total needs of the patient by the utilization of various resources.

Occupational Therapy is part of this modern institution. Its history dates back to 1929 when the Occupational Therapy program was initiated by the inspiration of Dr. Nils P. Larsen and Mrs. Laura N. Dowsett. The Occupational Therapy program was further supported by the keen interest of the Hospital Social Service Department who referred cases to the Occupational Therapy Committee, composed of doctors, social workers and volunteers.

The program in the early days was primarily diversional. Lauhala weaving classes were held for the patients. Other activities were available for those who were unable to attend these classes. Materials were collected by the social service workers and volunteers. After several months the interest and enthusiasm shown by the patients prompted a new step for further development in occupational therapy. The Occupational Therapy Committee decided to employ a regular craft instructor and this was initiated through the generosity of Mrs. William H. Marshall of Milwaukee, Wisconsin, and interested people who realized the need of an Occupational Therapy Department at The Queen's Hospital.

The occupational therapy program was becoming more and more therapeutic as time went on. Finally, the shop became a full-fledged department of the hospital. This was further encouraged by doctors, community-spirited citizens and friends. At first, the occupational therapy department had to depend on volunteer assistance, but as the interest of the doctors and patients increased, it was necessary to employ a registered occupational therapist in planning a more intensive program to meet the needs of the patient.

In 1931, a new wing was added to the hospital including an occupational therapy workshop. Today, the Occupational Therapy Department of The Queen's Hospital is the center of activities with three registered occupational therapists on the staff. There are two occupational therapy shops: one for the general and the other for psychiatric patients. The department is located on the second floor of the hospital. There are two lanais or porches, workshop, library and storeroom. Activities for general hospital patients are performed in the workshop and on the lanai. Functional diversional, recreational, pre-vocational and educational programs for bedside, shop, and outpatients are available. Treatments are given only upon prescription of a referring physician. A close correlation of physical therapy and oc-



P.T. and O.T. Consult

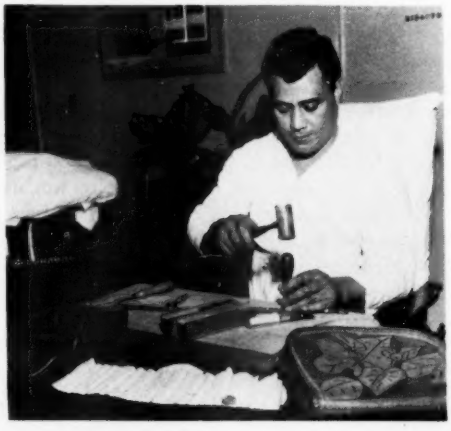
cupational therapy is maintained throughout the entire treatment program when both therapies are indicated. The physical therapy department is adjacent to the occupational therapy department, thus enabling us to facilitate a flexible program in treating the patient as a totality. Cooperation with social workers, Queen's School of Nursing, doctors, and other community resources is a vital factor in accomplishing our aims, purposes and function.

Another phase of our program extends to the psychiatric unit of the hospital. The occupational therapy shop is called *Hale Laulea*—meaning *House of Pleasure or Fun*. This shop is of recent development to accommodate the psychiatrists, nurses and social workers. Interviews, conferences, observations of patients in Occupational Therapy, and treatments in the mornings are possible by this addition. The Clinic is a unique set-up where there are men's and women's wards, a lanai, patio and the occupational therapy shop. There has not been any necessity to segregate the group. This arrangement offers the possibility of a more natural socialization of varied racial groups and creates a feeling of responsibility and encouragement. It develops initiative and interest in the various activities available for the patients.

Hale Laulea is a small shop surrounded by tropical greens. Here the patients spend their morning hours working on their projects as they listen to music. Those who feel better and are improved usually help the others. In-patients and out-patients work together in our shops. The occupational therapy program for psychiatric patients is flexible enough to meet their total needs.

The afternoon program for psychiatric patients is conducted on the occupational therapy lanai, where the general shop is located. The remote location of this shop gives the patients the opportunity to get away from the close proximity of the wards. Here they are engaged in recreational and diversional activities. The occupational therapy lanai serves as a vital social center more than a workshop. When the weather permits, group activity is further encouraged by outdoor sports usually held at the employee's volley-ball court. The recognition and utilization of occupational therapy as part of the treatment for psychiatric patients is very enlightening and encouraging. It is a contributory factor in the rehabilitation of the individual.

The occupational therapy programs of the general shop and the clinic are broad and flexible. Correlation of all the resources in the hospital and in the community is important and invaluable. Lectures and demonstrations are given to the student nurses of The Queen's School of Nursing, practical nurses, prospective students in occupational therapy, the schools and the various community organizations.



Learning to Carve Leather

The occupational therapy program for clinical training students was established three years ago. Since then, we have trained one or more students per year. The distance and the cost of the trip do not permit us to have more students. However, to those who have been here and those who are planning to come, a very intensive training program is planned which gives them an opportunity to work in an entirely different environment with people from varied cultural backgrounds. They are able to learn island arts and crafts; acquire knowledge of our community resources and facilities, and utilize them. We help them to develop a genuine urge for service to the patients and give them an opportunity to apply their theory.

The members of the Junior League continue to assist us in our library. They take the library cart to the wards and help the patients in the selection of reading materials. Other volunteers contribute their valuable time in our shop and we are more than grateful for their genuine interest and assistance.

Entertainment programs are held throughout the year for both the general and psychiatric patients together. Various groups in the community provide some of the entertainments and carry on group projects for the hospital patients. Their cooperation and interest are immeasurable.

We are grateful to our friends in the community for their contributions and their genuine interest in our work. With the continued support and interest of community-spirited people, friends, and professionals, we are able to give invaluable service to our patients and enable us to continue our work in the field of occupational therapy, which today, plays an important role in the rehabilitation of the individual, enabling him to re-adjust himself in his community as an asset.

(*Continued from Page 68*)

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OCCUPATIONAL THERAPY AT YPSILANTI STATE HOSPITAL

Mabel Wicks Nelson, O.T.R.
Director of Occupational Therapy

Forty miles west of Detroit, and eight miles west of Ypsilanti, is located the Ypsilanti State Hospital. The hospital grounds, including a 9-hole golf course and recreational area for patients, covers an acreage of 1200, with 800 acres under farm cultivation. This hospital was opened in July, 1931, to serve the residents of six counties in this section of the state. Several additional buildings have been erected since that time, and there is still to be erected a children's unit under the direction of this hospital but with a separate staff, and an auditorium and recreational center.

The medical services of the University of Michigan Hospital in Ann Arbor are available for consultation, and the surgical department personnel for surgery. Students from the University of Michigan Medical School affiliate for three-month periods in the summer serving as medical assistants in taking histories, neurological and physical examinations. The hospital has on its own staff rotating residencies for a medical consultant and a surgeon. The medical staff also includes two clinical directors, one to correlate clinical treatment of the patients within the hospital; and one to direct the outpatient clinics in the counties served.

The Occupational Therapy Department was organized in the fall of 1931 by Miss Mary E. Black, the first director.[2] The physical equipment at that time consisted of basement rooms in the administration building which were developed as craft centers, supplemented by

[1] Associated with the Department since 1935, Director since 1939.

[2] Director of Occupational Therapy 1931-1939.

ward classes. As the patient population grew the staff of therapists was increased to meet its need, until in 1938 the department moved into its present quarters, a separate three-story building, in size 280′ by 65′, which has become known as the Occupational Therapy Center, planned by Mary E. Black and designed by the late Albert Kahn, famed architect of Detroit. A small unit has been retained in the women's admission building for the treatment of patients who are too ill to come to the Center.

The Center was planned for the purpose of serving a larger number of patients and to provide a wider range of activities which might meet the interest of all types of patients. The workrooms are arranged so that specialized activities may be developed as well as the general group activities. The role of Occupational Therapy in the hospital is to function as an adjunct of the medical department, providing opportunities for patients to be active in situations which are pleasant and which are conducive to the solution of their particular problems.

Since the effectiveness of color therapy is increasingly recognized in our daily living we introduced it in the decoration of our admission unit several years ago. The walls are done in a light green, the ceilings with a tinge of pink. The reaction of the patients was so genuine and favorable that it was decided to use color when the Center was redecorated two years ago. The workrooms were done in a pastel green with corridors in cream, introducing a pleasing contrast with the exception of the basement which is cream color throughout. The one aspect of the Occupational Therapy Center which is most frequently mentioned by all patients is the cheerful, light work rooms which were planned for that specific purpose.

Assignment of patients for treatment is by physician's prescription; individually with many, blanket prescription with others. Unless specifically indicated by the physician the therapist arranges the type of activity in personal conference with the patient. The treatment is a progressive one, starting at a sufficiently simplified level to avoid undue stress until the patient's mental and physical capacities are known, and then is made more complex in keeping with the individual's ability and progress. Clinical reports are written after the first week's attendance, and then at the end of the one month, three months and six months routinely if patient is a long-term resident. Any unusual change in a patient's adjustment is reported at the time of occurence.

The type of activity used for treatment is determined primarily by the interest and need of the patients, and personnel available. For the physicians on the admission service who are making an initial diagnosis finger painting is used as a diagnostic aid. This necessitates frequent conferences with the physician to insure close correlation of the methods used with his plan for the patient. The physician's prescription may read, "Have patient paint what he sees or feels when he thinks of mother, father, brother or sister, self." The therapist's approach is her usual one of establishing a satisfactory inter-personal relation with the patient and then she invites him to take part in an experiment. From then on she must use her personal ingenuity and judgment in retaining her rapport and at the same time secure the desired result without arousing suspicion.

Other activities available include a wide range of crafts and several hospital maintenance units, or as they are often termed *hospital industries.* Our physicians believe that industrial therapy is of equal value with craft work and many patients go directly into hospital industries. Included under the supervision of the Occupational Therapy Department are the Furniture Repair and Refinishing, Sewing and Mending Rooms, Shoe Repair, Upholstery and Tailor Shop, Print Shop, and the Vegetable Preparation. The immediate supervision of these units is by skilled tradespeople and the ultimate purpose is production. They are operated, however, in such manner as to provide treatment for the patients through a responsible and productive activity. By a careful selection of employees not only on the basis of their trade skill but for their personal attributes, it has been possible to develop these industrial units so that there exists a healthy inter-personal relationship between the employee and the patient.

On first admission, as far as personnel makes possible, patients are contacted in the craft units and the initial treatment program is begun there. If interest in industrial activity is preferred, assignment to some unit within the Center is made at once; otherwise industrial activity is invited as soon as it is recognized

that the patient is ready mentally and physically for some greater responsibility. Presentation of the industrial work to the patient can often be made as an opportunity for the patient to demonstrate his or her improvement and ability to accept a different type of responsibility, and to meet a social adjustment different from the craft unit. If no activity within the Center is of interest to the patient, report of his interest is made to the superintendent of nurses, or the supervisor of men, by whom all other industrial assignments are made with the approval of the physician.

The construction of the Center is arranged by units which separate crafts from industrial. The transfer of patients during their treatment from one activity to another is often made to stimulate participation or interest, for the test of adjustment in a different environment, or for meeting problems of regression or sudden change of adaptability.

The office section is centered on the first floor where typing instructions are given by the department secretary for patients who wish to learn it from the beginning, and for those who wish to refresh their memory or skill. One-half of this floor is devoted to craft activities entirely, and the other to the sewing and mending rooms, personal sewing room and personal laundry. The accommodations in the craft unit permit the working together of the men and women in a natural association in the art room, bookbinding, ceramics, metal work and jewelry, and weaving. This not only provides a natural working environment but is also a good test of the individual's ability to adjust in a mixed group. It is recognized that the important part of treatment is not the activity itself but the environment created and the patient's adjustment thereto. The therapist's approach to all patients is to seek first their interest or what they themselves would like to do, and to establish a friendly working relationship. Lacking response from her patient, the therapist offers suggestions. Active participation and acceptance of responsibility are always encouraged; a natural exchange of social interest in fellow patients and their work is sought.

The production of a marionette show illustrates what can be achieved in the correlation of varied interests and aptitudes, and develops good teamwork. A young man with considerable artistic talent in water colors wrote the script; interested patients with more mechanical skill made the bodies of the marionettes in the wood shop; patients with special art talent modeled the heads from papier-mache and decorated the faces in water color; women skilled in sewing designed and made the costumes. Considerable research in history of costumes was at times necessary to provide the correct design. The role of the therapist was that of the counselor and guide, filling in with participation in the work wherever needed. Direction of the manipulation of the marionettes and production of the show itself was the responsibility of the therapist primarily. It proved an excellent project for resocialization of some patients, the building of confidence in others, and in some the discovery of a latent talent. The show was presented in the gymnasium for the benefit of a large group of patients who were not active regularly in the occupational therapy department. (Recreational therapy in this hospital functions as a separate department.)

Not all the craft rooms are used solely for the making of the craft itself but are used as semi-industrial activities where work is accomplished which contributes to the maintenance of the hospital. In the bookbinding room printed forms used in the hospital are bound in pads; discard forms are made into scratch pads; and the repair or resewing of the hospital library books is a regular responsibility.

The making of curtains for the hospital cafeterias illustrates how the work of the various units may be correlated. Ordinary burlap sacks which have been laundered are raveled in the men's craft section, woven into fabric on floor looms in the weaving room, made into curtains in the sewing room, and blockprinted in the art room. The result is a very economical curtain, one which is decorative and not recognizable as the humble burlap. What is the benefit to the patients who assist in this project? Some of the workers are among our permanent residents who have found an activity which makes them feel they are still needed; a daily routine of responsibility is built for them which gives them a sense of security in that they are an integral part of the hospital life. For others who learned a new craft there is the satisfaction which is achieved in making something which is useful, as well as discovering an inter-

est which can be adapted as a diversional activity in the home. Block printing is utilized often by patients in decorating their own greeting cards, in printing fabric for drapes, and other home decorations. There is also an economic saving for the hospital which appeals to the business manager, and good inter-departmental relation is established with the dietary department in providing attractive draperies for their cafeterias.

The other half of the first floor of the building accommodates the sewing and mending rooms which are equipped with forty-five factory type sewing machines, the patient's personal laundry, and the personal sewing room. The privilege of laundering personal clothing can be a very therapeutic thing for women patients especially. Each ward has an assigned day and those patients who are interested attend. This is frequently an ideal opportunity for the therapist, especially in the admission unit, to establish rapport with the patient and arouse interest in some other activity. Approximately 100-125 patients are actively engaged in the sewing and mending rooms regularly and are trained in the operation of the machines by making some new garments and by the repair of used clothing, or in hand sewing. Some patients by preference do only the industrial work. Patients are trained in the various activities and thereby develop confidence in work responsibility, or find an acceptable release for their feelings. The surgical dressings for the hospital are also prepared here which provides a clean, not over-taxing activity for the patient early in her illness who is not interested in crafts, nor able to operate a sewing machine. Opportunity is also provided for the patients to repair their own clothing, and to make new garments. It is the ultimate goal to develop the personal sewing room into a dressmaking unit where patients may learn this as a basis for a new means of livelihood, or as a helpful asset in their own home.

The physical lay-out of the second floor of the building is similar to the first, with one-half devoted to men's crafts, and one-half adapted for special treatment rooms. This latter section is not fully organized as yet due to lack of personnel. It is fitted, and at times has been used for the purpose of working with large groups of semi-disturbed or hyperactive patients who are inclined to be destructive of clothing and other materials. Success has been achieved in diverting this destructive drive into something constructive, usually beginning with the familiar and simple tearing of rags and raveling of burlap for weaving purposes, with progression to more complex activities as improvement was noted.

One room is equipped with an electric stove for the purpose of giving instructions in simple cooking and waitress work which would be beneficial not only from the practical angle but for the socializing aspect as well.

The men's craft section serves as the admitting unit for the male patients. These men are the acutely ill and the long term patient. This unit is in charge of a man skilled in woodwork and a young woman therapist who share equal responsibility. The division of the unit provides for an art room, flower room, rug room, woodwork room, paint room and minor crafts. On occasion we have had some interesting experimental projects achieved in the art room. A middle aged patient who had been a commercial artist was asked to take the responsibility of instructing other patients in art work. The encouragement of patients to assume such responsibility wherever possible is a general procedure where it is felt the patient will benefit. Approximately ten different patients worked under his direction and they confined their activities entirely to the medium of pastel chalk. In general patients were hesitant to do originals but preferred to make copies of the accepted masters. The response of the patients to the patient instructor was excellent; some who had shown little response elsewhere in the patient-to-patient relation showed marked progress. Instructions in the technique of working with pastel chalk was given and approximately fifty creditable pictures were finished. Frames for them were made in the woodcraft shop, and the artists in turn decorated the frames to harmonize with the pictures. They were used as decorative furnishings throughout the hospital. Most of the student-patients were discharged from the hospital; the patient-instructor remains among our permanent residents and is still active in art work of an experimental nature.

In the woodcraft shop is sought the patients who later become workers in the furniture repair unit. If they show aptitude and skill with tools they are approached as to their interest in

some industrial responsibility when their condition warrants.

The rug room provides activity for the patients who physically may not be able to do more strenuous work, and for those whose mental confusion or regression permit nothing more complex. All types of rugs are made on upright hand looms and introduction to the four-harness hand and floor loom is made. Patients with aptitude for weaving are given an opportunity to work in the general weaving unit. Many of our permanent residents find a helpful and satisfying task in this room. Preparation of the burlap for weaving and rug making begins here.

Flower culture is encouraged among the patients but no extensive work is done. African violets have been a specialty as well as some plants which lend themselves naturally to plant boxes or ferneries which we provide for ward use when possible. The room is cared for almost entirely by interested patients. In the summertime patients who wish are able to have outdoor gardens near the Center.

The basement floor is devoted entirely to industrial, or hospital maintenance units. The supervisors of these units are classified by Michigan Civil Service as Industrial Therapy Shop Foremen. The furniture repair and refinishing, and the upholstery rooms provide occupation for those who are either long-term residents of the hospital or who are about ready for discharge. For the latter it provides opportunity to test their ability to do productive work and accept responsibility; for the others it provides a daily task which lends a feeling of importance to them as individuals. All furniture repair and upholstery for the wards and employees' residences are handled by two cabinet makers and an upholsterer with the aid of patient help. The print shop which is in the process of organization will handle the printing of forms for the hospital. In the shoe repair shop, the upholstery, and furniture repair there is opportunity for patients to learn the basis of a trade so that one could serve as an apprentice when discharged, if the individual is interested to this extent.

The vegetable preparation unit employs both men and women where the daily supply of fresh and root vegetables for the hospital is prepared. Music therapy has accidently and effectively been combined with vegetable preparation. A piano sent to the Center for discard was used for the Christmas party and retained there at the request of the patients. The result is that the general working tone of the patients is greatly improved. They work with better application in order to finish a bit early and have "request numbers" by the supervisor who is able to comply. It is no longer difficult to get workers for this unit.

Throughout the Center, recognition of the various holidays is made by means of some simple gesture of a party such as refreshments of cookies and coffee, pop corn, apples or candy which are furnished by the hospital. This helps to create a normal, home-like atmosphere. As is fitting the celebration at Christmas time is the most elaborate with open-house throughout the Center, so that each may know what the other does. The students from the Occupational Therapy Club at the Michigan State Normal College present a short play and group carols are sung. Expressions of appreciation which follow are proof of the therapeutic benefit. One other aspect of the Christmas season which benefits many is the preparation of socks which are distributed Christmas morning by the ward personnel throughout the hospital. The socks are made of tarleton in the sewing room early in October and November. Two days before Christmas, the filling of the socks takes place in true assembly-line fashion, characteristic of our motor-city area. Approximately 200 pounds of popcorn is used, a ton of candy, and dozens of oranges. The filling is accomplished in two hours through efficient cooperation of forty-five patients and a few employees who supervise.

Student training is another important phase of our program. We have Occupational Therapy students affiliating for clinical training for three months from the three Michigan Colleges — Michigan State Normal College, Ypsilanti; Wayne University, Detroit; Western Michigan College of Education, Kalamazoo, and the University of Wisconsin. Our resident students must be limited to four because of the crowded housing conditions. We anticipate increasing the number of affiliates as soon as the housing situation permits. Several preclinical students from Michigan State Normal College commute from Ypsilanti for one month of observation for which they earn college credit. The hospital also has an affiliate school of Nursing of approximately 25 students. These

student nurses spend two hours daily for two consecutive weeks in which they receive lectures in theory and application of occupational therapy, and instruction in such crafts as they may encounter in ward service. Later they spend one full week of active participation and observation of patients in the workrooms, coming two or three at a time. As a part of the Mental Hygiene Program of the State of Michigan, the hospital has an organized in-training course for attendant nurses who also affiliate for one week's observation and instruction as a part of orientation to the over-all program of treatment for patients in the hospital.

As it is possible to increase the staff quota of therapists there is opportunity for considerable expansion of our program within the Center, as well as the organization of ward work for those who are unable to come to the Center. To date the expansion of activities has been through the addition of student training and employment of tradespeople who have contributed ably in industrial therapy.

SPECIAL NOTICES

1949 CONVENTION

AUGUST 23-25

Yes, that's the date for the 1949 AOTA Convention at the Book-Cadillac Hotel in Detroit, Michigan, with the Michigan Occupational Therapy Association hostessing the affair. *Dynamic Processes in Occupational Therapy* has been chosen as the theme of the convention in Detroit, the Motor City.

Way out west in '47 and to the east coast in '48 now in '49 OT's from all directions will gather in Detroit as AOTA convenes in the midwest. Detroit is accessible by all means of transportation, so a record attendance is anticipated. A delightful vacation on the Great Lakes, resorting in the land of Hiawatha, roughing it among the haunts of Paul Bunyan, or streamlined travel from the far corners direct to the automobile city — all can be planned to make the month of August a happy vacation, plus facilitating attendance at the 1949 convention.

The convention proper opens Tuesday morning, August 23, with President Winifred Kahmann addressing the business meetings. That afternoon one of the nation's outstanding psychiatrists, a dynamic speaker, will attract an eager crowd, alerted to hear about *The Dynamics of Personality.* Recommendations from all directions are coming in for the demonstration of the Amputee and Brace Re-Conditioning and Re-Training Program by the Michigan Crippled Children's Commission. They will be seen in the afternoon. By evening opportunity will be made for job seekers to meet with those who have enticing offers.

Wednesday forenoon four symposia will go on simultaneously. It's a toss-up which one to attend: 1. Wheels of Progress in Rheumatic Fever; 2. Machinery for the Rehabilitation of the Tuberculous; 3. P.T. and O.T. with the Cerebral Palsied; 4. Multiple Sclerosis. Before lunch all will convene to hear about "The Mechanics of Psychodramatics." The same afternoon, symposia, four-strong, will allow choices from: 1. Spokes of the Rehabilitation Center; 2. Chest Surgery; 3. Mobilizing O.T. (homebound); 4. Panel on Epileptics.

Thursday forenoon those attending will have opportunity to learn more about some of the foundations that work directly or indirectly with occupational therapy. Thursday afternoon trips will be made available to all O.T. departments in the city, visitors are cordially invited to include as many O.T. centers as possible.

* * *

Following the convention proper, the 1949 Institute will convene, all day Friday and Saturday forenoon. Mabel Wicks Nelson, O.T.R., Director of O.T. at Ypsilanti State Hospital, is a very excellent choice for chairman of the institute. The theme will be *Engineering for Performance.*

AMBASSADOR BRIDGE

The fee for the Institute, $7.50, provides attendance to the two sessions on August 26 and one session on August 27. The Institute Committee will appreciate an indication of your intention to attend. Your name and address on a penny post card to Mrs. Mabel W. Nelson, O.T.R., Box A, Ypsilanti State Hospital, Ypsilanti, Michigan, will be sufficient.

* * *

Registration for convention will start Saturday forenoon, August 20, as the pre-convention meetings begin. Upon the recommendation of the Permanent Convention Committee the Board of Management established for the convention the registration fees as follows:

O.T.R. with AOTA membership card—$5.00
Student AOTA member with membership card—$1.00
All non members—$6.00
Part-time attendance—$2.00 per day
Complimentary admission is extended to allied professional groups upon presentation of a membership card.

* * *

A large commercial exhibit will be located near the registration desk. In thirty-two booths business concerns will display products of interest to all occupational therapists. Plan to attend the exhibit to gain new ideas for use of familiar products and new techniques to broaden and enrich the scope of our treatment program.

This is the first time the American Occupational Therapy Association has sponsored a commercial exhibit. All other commercial exhibits have been the result of the effort of local committees. If we evidence interest in this enterprise the National Association will plan an exhibit for every convention. Put forth your effort to assure us of a repeat display by attending the national convention and visiting the commercial exhibit.

* * *

The committees in charge are striving to make a happy balance of work and fun for the convention. So, interspersed are such events as the Paul Bunyan Breakfast, the Introduction-to-Michigan-Luncheon, and the Schools Dinner with *OUR HERITAGE* as the theme. Wednesday nights' banquet theme will be *Blue Prints for the Future.* Plans are afloat to make a *moonlight* a part of the convention.

* * *

Michigan urges everyone to attend the 1949 convention. Michigan also reminds all convention planners to provide sufficient time to visit some of the outstanding spots in and around Detroit. Cranbrook, an educational center just north of Detroit, offers a haven of wonderfully fine exhibits in its Academy of Art, Institute of Science, and Christ Church. Ideally located in a beautiful wooden area, Cranbrook offers surroundings that compete with fine architecture and exhibits within.

Greenfield Village and the adjacent Museum out on the edge of Dearborn are a monument to the great automobile giant, Henry Ford. A

trip to Detroit would not be complete without visiting the fine historical restorations, Thomas Edison's laboratory, authentic craft shops, Martha-Mary Chapel, tintype house, the apothecary shop, and many others one reluctantly leaves.

Within a few minutes from downtown Detroit, out East Jefferson Avenue, is an unpretentious pottery shop. Unnoticed though it is, Detroit and Pewabic Pottery may well be proud

of the owner and founder, Mary Chase Stratton, whose pottery, done in unusual irredescent glazes, has been honored in many exhibits the country over.

Cerebral Palsy Workshop

The Division of Special Education of the School of Education of Syracuse University, Syracuse, New York, in cooperation with the New York State Association for Crippled Children, Inc., and the National Society for Crippled Children and Adults, Inc., has announced a WORKSHOP ON THE PROBLEMS OF CHILDREN AND ADULTS WITH CEREBRAL PALSY to be held July 25 through August 12, 1949.

The Workshop Director is William M. Cruickshank, Ph.D., Director, Special Education for the Exceptional, School of Education, Syracuse University.

The Workshop Coordinator is: Mary Eleanor Brown, M.A., Physical Therapist, Field Consultant, New York State Association for Crippled Children, Inc.

The purpose is to offer by lecture, group discussion and demonstration, recent advances in cerebral palsy, to professional workers, including: physicians, nurses, nutritionists, physical, occupational and speech therapists, educators, psychologists, recreational and social workers, vocational advisers and placement officers, trade school staffs, employers' personnel officers.

Registration is restricted to 40 persons. Address inquiries to Workshop Director.

Students may register for the Workshop for two hours of graduate or undergraduate credit or they may audit the course. In either event the fee will be $17.00 per credit hour or $34.00 payable on the date of registration.

Salary Raises in New York

Salary increases for more than 500 occupational therapists in the New York State Department of Mental Hygiene becomes effective April 1, 1949, according to a news release by Miss Virginia Scullin, Director of Occupational Therapy.

Cost of living bonuses equal to 15% of the first $3000; 10% of the next $2000 and 5% of base pay over $5000 were also added.

The new pay-scales are as follows: $2208 to $2898 for Occupational Instructors, $2760 to $3450 for Occupational Therapists, $3582 to $4308 for Senior Occupational Therapists, $3978 to $4803 for Supervisor of Occupational Therapy. The new salary scale is based on a 40-hour week, 5-day week, with 4 weeks vacation and with sick-leave and retirement benefits.

These recent salary raises of the New York State Department of Mental Hygiene bring the level of salaries up to those paid all over the country.

WESTERN CONFERENCE OF O.T. AND P.T.

The Occupational and Physical Therapy Associations of British Columbia and the State of Washington are sponsoring a *Western International Conference of Occupational and Physical Therapy* to be held in Vancouver, British Columbia, May 28-30, 1949.

The program theme is *Present Day Trends in Occupational Therapy and Physical Therapy* and is planned to include:

Panel on Physical Medicine with an American O.T. and Canadian P.T. joining a discussion presented by a prominent Canadian physiatrist.

Panel on Arthritis.

Luncheon meeting at which time the emphasis will be placed on psychosomatic medicine and its particular relationship to occupational therapy and physical therapy.

Dinner meeting preceded by a cocktail party. Theme of the meeting to be tuberculosis with an emphasis on the newer trends in occupational therapy and physical therapy as regards the post-surgical tuberculosis patient.

A tour of hospitals and clinics in Vancouver.

Registration will be held Saturday morning from 8:00-9:00 at Shaughnessy D.V.A. Hospital. The fee will be $7.00 which will include registration, luncheon, cocktails, dinner and a tea.

Any person desiring hotel accommodations may write to Miss J. M. Forbes, O.T. Dept., Shaughnessy Hospital, Vancouver, B. C., before May 10th, 1949.

All occupational therapists west of the Mississippi are invited to attend the conference. If none have been in the Pacific Northwest there is no more appropriate time than May to see the beauty and scenic grandeur of this section of the country.

A Letter to Clinical Training Directors

The American Occupational Therapy Association through its Education Office has been and is in the throes of a three-year Educational Research Program. Most of us know something about this program, but few of us know just how fully it affects the clinical training director.

In the development and execution of this plan, the Education Office has working with it the Education Committee and its Sub-Committees on Schools and Curriculum and Clinical Training. The total program includes research in the entire picture of Education, from selection of students, through the didactic and technical training at school, clinical training in the field, registration in the profession and finally work performance.

May we at this point emphasize one important fact: The entire procedure of scientific educational research necessitates experimentation. All records, forms, questionnaires and surveys, before any radical change is made, must be analyzed, and the findings presented to the Education Committee.

Very close integration of the total program is essential to produce the best results in this study. The combined efforts and co-operation of many occupational therapists both in the teaching and practical fields are necessary to accomplish this.

The clinical training director has been asked to do much and is going to be asked to do more. It is our sincere hope that all of you will go this *extra mile* with us for the benefit of the profession and future occupational therapists.

Listed below, with explanations, are the current projects in this program which affect the clinical director:

1. RATING FORM—INTERPRETATIONAL KEY—DIRECTOR'S GUIDE—AND RATER'S GUIDE. Since the student now receives 20% weight of her total registration score on performance during clinical training, it has become necessary to standardize our method of grading. In answer to the many questions that apparently exist in the field regarding this Form, Key and the Guides we would like to emphasize the following points:
   a. They are in the experimental stage.
   b. They are to be analyzed as to their effectiveness.
   c. Clinical training directors are asked to return two copies of the student's report promptly to the schools at the end of each affiliation. The school director in turn sends a copy to the Education Office, where it will be used as a base for the analysis (and also for evaluating the student's performance in clinical training for the registration examination score).
   d. Specific suggestions and criticisms regarding this material will be called for shortly by the Education Office. *Watch for it* and be prepared to help.
   e. We *do not* intend to ever adopt a *"secret key"* method of grading students in clinical training.
2. CLINICAL TRAINING POOL.

   This has been established to take care of the unexpected vacancies which occur in assignment of students for training and in the clinical training schedules. Instructions and forms have been sent to you by the Education Office.
3. RECIPROCAL EVALUATION PLAN.

   In the Director's Guide on Page 2—Essential #7 reads "Where an established training program exists, there should be a clinical training meeting per year for the exchange of constructive evaluation. Also the school must send to the center, yearly, a composite report of their evaluation of students' reactions to training and the center must report to the school on the students' preparation and needs."

   In order to help fulfill this objective we are asking the schools during the coming year to have their students fill out a report form which must be returned to the school in duplicate. At the end of the year these forms are to be studied by both school and clinical training directors and through conference or correspondence an evaluation of the program can take place.
4. ACCREDITATION OF CLINICAL TRAINING CENTERS.

   Much thought has been given to this matter in the past two years. Requests for it have come from many clinical training directors. A committee has prepared a preliminary form for self-evaluation of training centers as a first step toward accreditation. In this experiment, clinical training centers will be picked at random with respect to

geographic location and the areas of occupational therapy, and this self-evaluation form will be sent to them for completion. *If* you are chosen, please help.

A study will then be made and further work done toward a final system of accreditation.

In summary—

These four projects of the Educational Research Program, which pertain to the Clinical Training Director, deserve your consideration.

The forms and questionnaires to be used are being edited in the Education Office and have been or will be sent to you in the near future.

Remember they are not in their final form, but can be changed after one year's use and after analyses have been made.

Please help us by doing your part.

Sincerely,

Margaret Gleave, OTR, Chairman
Sub-committee on Clinical Training
Helen Willard, OTR, Chairman
Education Committee

VISITOR FROM UNION OF SOUTH AFRICA TO NORTHERN CALIFORNIA

MISS MARY DUDLEY-SMITH, organizing occupational therapist from *The UNION OF SOUTH AFRICA,* who has been visiting in the United States, arrived in the Northern California Area January 21, 1949.

Miss Dudley-Smith, who is an occupational therapist employed by the Red Cross, is visiting in this country on a Carnegie Grant to study methods used here in Occupational Therapy Schools and Departments. She visited as many schools, hospitals and rehabilitation centers as her limited time would permit. Among installations visited were the Mills College and San Jose State College Occupational Therapy Schools, California State Cerebral Palsy School at Redwood City, Kabat-Kaiser Institute at Vallejo, California; and the Veterans Administration Hospitals at San Francisco, Palo Alto and Oakland. All who were visited by Miss Dudley-Smith enjoyed her enthusiasm.

On the lighter side, since no trip to San Francisco is complete without seeing the view from the "Top of the Mark" and dinner at Fisherman's Wharf, all of these were sandwiched into busy days, and as an additional attraction the Chinese New Year was celebrated in San Francisco's own Chinatown.

Miss Dudley-Smith made many new friends in this area, and we all wish her the greatest success in her organization of occupational therapy schools and departments on her return to South Africa.

Miss Eva Brostrom

DANISH THERAPIST VISITS HERE

The first occupational therapist to be granted a scholarship by the International Red Cross studied in the United States for four months this winter. She is Miss Eva Brostrom from Viborg, Denmark. During her four months' stay in this country she visited occupational therapy departments in Pennsylvania, New York, Massachusetts, Ohio, Indiana, Wisconsin, Georgia, and Virginia after studying for six weeks at Walter Reed Hospital and four weeks at the University of Maryland Hospital.

Miss Viborg was impressed with the "excellent training in anatomy and medical subjects" given student occupational Therapists in this country and for the excellent rapport therapists have with physicians in charge of the treatment units.

Miss Viborg is the chief occupational therapist at the Danish Red Kros Kuranstalt in Viborg which is a rehabilitation and convalescent hospital. General medical, orthopedic, and mental cases are treated there as well as Norwegian polio cases. During the war Denmark helped Norway obtain food. In appreciation Norwegians built a hospital to take care of asthma patients from Denmark in Norway. In return Denmark offered to care for Norwegian polio patients.

The hospital in Viborg was opened in 1922 and occupational therapy was introduced a few

years later. Most of the therapy is done by nurses skilled in crafts. "Emphasis is on prevocational training in weaving, carpentry, metal work and shoemaking."

Student therapists from the occupational therapy school in Copenhagen trained at the hospital before the war and hope to resume training there again soon. The school was begun in 1935 and accepts eighteen students at a time.

Miss Viborg is a member of the Board of Management of the Danish Occupational Therapy Association. The group is working, like all similar groups throughout the world, to improve and increase the basic training for its members and thereby raise the quality and standards of the profession.

* * *

Letters to the Editor

December 16

Already there is another job for an O.T. here in Alaska. Please put us on the roster of people wanting O.T.'s. This time it is for the Children's Orthopedic Hospital at Sitka, Alaska. This hospital is run by the Alaska Native Service, and I would guess there are about 60 children. The Alaska Crippled Children's Association is sponsoring the demonstration to prove the value of O.T. at Mt. Edgecumbe. There is a TB Hospital on the Island also, with both children and adults. . . . It is about 40 minutes from Juneau, the capitol, by plane. It is real, and I mean *REAL* pioneering though, and requires a sturdy person who can put up with everything and nothing, and stick it thru. A new building is under construction now to enlarge the beds available. . . . Most of the children have orthopedic tuberculous conditions. There is a big job to be done here, and it can be a demonstration spot in the Territory.

The weather is much like that of Seattle, Washington. . . . It is isolated except for the town of Sitka, with its old Russian church, lumber mill, totem park, Pioneer Home for old sourdoughs, a few stores, and the only Junior College in the Territory. It is also amid beautiful scenery. The employees both for the Vocational School and for the hospitals live in what the Navy left — a nice building which was B.O.Q. for them. Because the Vocational School is also on the island with the hospitals, a real program of rehabilitation should be easily possible for those TB patients. The whole setup definitely has possibilities. But lots of hard work, and mighty little to start with . . .

We are terribly busy here in Seward. Two boats are due tomorrow and great excitement is prevalent in the town. I hope I can see them come in, as it is a real thrill with merchants running into the street with binoculars to identify them as they come up the harbor. We isolated creatures in the great North sure appreciate having the strike over. I get quite annoyed at times with the shortages and lacks, and have no O.T. stuff as yet — there just is none to buy. Christmas is the big item, and we try to invent decorations. We expect 2 nurses and 1 patient on the Baranoff (one of the ships). Isn't it exciting? Our patients often fly to us. The Eskimos are darlings — sweet, loving and lovable, and so very appreciative. The children are adorable with fat round faces and black eyes, and smart as whips. Their schooling is very sketchy, if any, and I have been using that new degree in Education and praying for more practical ideas. We are working on getting a real live teacher here, and may succeed in a few more months.

Please give my best to all the O.T.'s. . . . And drop us a note — or — well, even a bill makes mail! Do we have any word from the people in India, Australia, South Africa or Palestine? Wonder if they would like to have a world O.T. association?

Best wishes,

(Signed)

Alice M. Hussey, OTR
Seward Sanitorium
Seward, Alaska

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DELEGATES DIVISION

CONNECTICUT

Delegate-Reporter, Ruth Kenzie, O.T.R.

Two meetings were held by the Connecticut Occupational Therapy Association during the year 1948. The spring meeting was held in conjunction with the annual meeting of the Connecticut State Medical Society at Fairfield, Connecticut. Following the business meeting Dr. Temple Burling discussed the program underway in the rehabilitation of the mentally ill under the National Committee on Mental Hygiene. Dr. Daniel Griffin, a member of our own association, scientifically and humorously talked on "Psyche-Soma-and Sense". Twenty-five members of the Association enjoyed an impromptu dinner party after the meeeting.

The September meeting was held at Hotel Bond, Hartford, Connecticut. Following the business meeting, the program included the delegates report of the National Occupational Therapy meeting held in New York by Miss Bertha Piper; a discussion of the rehabilitation program at the Veteran's Home at Rocky Hill, Connecticut, given by Dr. Nila Covalt, Director of Physical Medicine, and, "Occupational Therapy in Rehabilitation" discussed by Roland Spaudling, Vocational Educational Director at New York University.

Our former delegate, Bertha Piper, forceably brought home to us the outstanding work of the personnel of our National Office in spite of handicaps and stressed the importance of the support of the State Organizations. Ways and means of aiding the publicity and recruitment phases of the program of the National Office were discussed and a more concrete evidence of our interest and loyalty was manifest in a $50.00 check sent to National with our blessing. As other state organizations already know our enthusiasm and concern included all of you — yes, and even Shakespeare.

OFFICERS

President: Miss Arvilla Dyer, O.T.R., U. S. Veteran's Hospital, Newington, Connecticut.
Vice-President: Miss Frances Miller, O.T.R., Hartford Hospital, Hartford, Connecticut.
Secretary-Treasurer: Miss Eleanor Kille, O.T.R., Southbury Training School, Southbury, Connecticut.
Delegate: Mrs. Ruth Kenzie, O.T.R., Laurel Heights Sanatorium, Shelton, Connecticut.

WISCONSIN

Delegate-Reporter, Charlotte Kersten, O.T.R.

The Wisconsin Occupational Therapy Association begins its year in May. Therefore, the report on meetings will be given from last May and will include the future meetings planned through May, 1949.

1. May, 1948—The Annual meeting was held at the College Woman's Club in Milwaukee. Mrs. Johnson presented a program on flower arrangements. This was followed with a business meeting at which time the following was discussed and voted upon: to give a subscription of AJOT to the Milwaukee Public Library and to make a bibliography of present material in the library for the purpose of adding books to complete the library's collection; minor changes in the constitution were accepted. Officers for the next year were elected and took office.

2. June, 1948—The annual picnic was held at the Children's Convalescent Home. The children at the home presented a program for the group.

3. November, 1948—A meeting was held at the Curative Workshop at which time the members worked on articles to be sold at the Talent Sale in December. The Delegate's report was also given.

4. December, 1948—The Talent Sale was held at the Curative Workshop under the direction of the ways and means committee to raise money for the scholarship funds at the Milwaukee Colleges which the WOTA supports. Handmade articles were donated by the members. Proceeds from the sale totaled $195.00.

5. February, 1949—The meeting was held at Milwaukee-Downer College presenting a program of movies. Mr. Rumsey from the State Rehabilitation Division showed their film on rehabilitation. Miss Jeanne Foy showed the amputee film from the Curative Workshop. A third film was shown on *Art in Rural Life.*

6. March, 1949—Dr. Gilbert Rich will talk to the Association on the International Health Conference which he attended in London last summer. This will be followed by a business meeting.

7. April, 1949—A joint meeting with the physical therapists will be held in Madison at the University of Wisconsin. This will be a

two day meeting and will feature outstanding speakers from the University Physical Medicine Staff.

8. May, 1949—Early in May the Association will participate in the Tri-State Hospital Assembly in Chicago.

9. May, 1949—The Annual meeting with election of officers.

Community Affairs recognizing O.T.—Requests have come to many members of the group to be speakers at the meetings of many organizations throughout the state. Two television programs from the Milwaukee station have been given on phases of O.T. The career conference at the University included an Occupational Therapist.

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KENTUCKY O.T. ASSOCIATION

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Number of meetings held during past year—5
Membership—20
Average attendance—12
Nature of Programs:

Talks by Doctors:

1. Rehabilitation in V.A. Hospitals.
2. Place of O.T. in Mental Hospitals.
3. Annual Founders Day Banquet, report on convention.
4. Speech correction with crippled children by speech correctionist.
5. Program of King's Daughters Home for Incurables.
6. Tours of various O.T. Departments.

Outstanding Features—None.

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SCHOOL ACTIVITIES

MILWAUKEE-DOWNER COLLEGE

This year the Occupational Therapy Club at Milwaukee-Downer College set education, entertainment, and enthusiasm as its immediate, yet far-reaching, goals. The faculty advisor, officers, and committee members planned the monthly meetings and various activities according to these specific aims.

In combining these educational and social factors, various aspects of the student's future profession are stressed while giving her an opportunity to mingle with other O.T.'s. Thus, she is able to broaden her understanding of actual therapeutic work and keep abreast of advances being made in the field. This year at one of the meetings, dramatic mental health records were heard; at another, a clinical student reported on her training experiences and answered questions during a discussion period. At a future meeting a leading psychiatrist will speak on the subject of happiness. Plans are also being made to visit Muirdale to study the occupational therapy program in a tuberculosis sanatorium.

The senior O.T.'s have had an opportunity for even more first-hand knowledge and experience. At the Veterans' Hospital at Wood, Wisconsin, they studied the various divisions of the Department of Physical Medicine and observed the different types of therapeutic activities in progress. In addition to their regular medical lectures at the Hospital for Mental Diseases, they assist with the bi-weekly square dances given for some of the patients.

Observing and working with adults in the orthopedic and psychiatric areas is, however, only one phase of their varied program. They have also had valuable experience in working with children. During the first semester, several seniors took charge of after-school entertainment for the younger boys and girls at the Urban League, the Negro Social Center. There three times each week they directed the various crafts, both quiet and active games, and the music groups. One of the students organized a girls' chorus to sing for the Christmas service

at a Negro church. Then, for some 300 grade-school children, the seniors gave a puppet show which included an amusing rural melodrama and an original nursery rhyme skit.

Not only is much diversion derived from participation in these activities, but entertainment is an essential part of each meeting. Furthermore, three special social events are held. The first meeting in the fall is a mixer-meeting especially for freshmen and transfer students. This gives them a chance to meet upperclassmen and faculty in the department. In December a Christmas party takes the place of a regular meeting. Then in May, club activities end with a picnic for all O.T.'s, both college students and those returning for the Seminar after their clinical training.

Besides these activities, the club contributes in other ways to the college and the community. Articles made of paper and felt were sold at Christmas Carnival, a benefit sale to which all the clubs at the college made donations. Another project was the stenciling of gift paper which was sold at the Curative Workshop for the Wisconsin O.T. Association.

Again the annual Craft Seminar was conducted with four weekly two-hour sessions. These evening meetings, first of all, enabled faculty members and other students to make Christmas cards and gifts of plastic, wood, and leather. Then they gave the O.T.'s an opportunity to teach these crafts. They learned how to organize classes, order supplies in large quantities, explain processes effectively, and conduct the groups in a systematic manner.

Recently, following an all-day meeting of the directors of the departments with which the students are affiliated during their clinical training period, tea was served by the senior group. At that time, the students met many of the directors with whom they will later be associated.

With these various educational and social aspects, there must be interwoven an abundance of enthusiasm—enthusiasm toward the club, the profession, and their relationship. This can be achieved only when a student realizes that each responsibility she assumes is a significant one, and the more opportunities of which she takes advantage, the better will be her background. When the club has made it possible for its members to participate in numerous worthwhile projects, then its program will have accomplished its purpose.

O.T.—T.V.

Some occupational therapy students took part in a television program devoted to activities at the University of Southern California on February 10th.

Lt. Mildred Bond explained the purpose of occupational therapy treatment to Miss Olive Nolan, a reporter on the Los Angeles Daily News. In a small shop set-up for the show, Arthur Bockstahler, a senior student, was weaving, Pauline Pupis, O.T.R., of the Los Angeles Veteran's Administration Center was kneading clay and Harriett Zlatoklavek, O.T.R., of the University of Southern California was carving wood.

Only four minutes of the fifteen-minute program of school activities was devoted to occupational therapy but an amazing amount of information was crowded into the time. Lt. Bond escorted Miss Nolan around the shop and explained how the crafts were used therapeutically.

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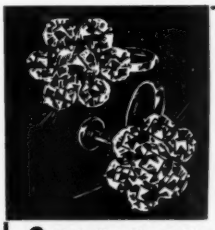

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